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By

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MAINTAINED WEIGHT LOSS: FACILITATORS AND BARRIERS

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This work or any part thereof has not previously been presented in any form to the University or to any other body whether for the purposes of assessment, publication or for any other purpose (unless otherwise indicated). Save for any express acknowledgements, references and/or bibliographies cited in the work, I confirm that the intellectual content of the work is the result of my own efforts and of no other person, beyond the role expected of my research supervisors Dr Wendy Nicholls and Professor Magi Sque.

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Word Count Summary

Research Dossier	Page Number	Word Count
Chapter 1 – Introduction	16	4,085
Chapter 2 - Literature Review	32	7,697
Chapter 3 - Empirical Study	62	3,833
Chapter 4 - Findings	80	8,424
Chapter 5 – Discussion	115	4,555
Chapter 6 - Critical Appraisal	134	2,754
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Preface

This work contained herein is a representation of my studies at the University of Wolverhampton to ultimately contribute towards the completion of the Practitioner Doctorate in Counselling Psychology course. This portfolio has various sections which depict the progression through my development as a counselling psychologist in training; highlighting my transition from a student to the independent, highly motivated practitioner I feel I am today.

This portfolio contains a Research Dossier which is comprised of the following chapters; Chapter 1 - Introduction, Chapter 2 - Literature Review, Chapter 3 – Methodology and Methods, Chapter 4 – Findings, Chapter 5 – Discussion and Chapter 6 - Critical Appraisal.

Accompanying this portfolio is a Confidential Attachment which will be kept separately. This will contain work completed over the course of the three years and includes a process report, client study, personal journal summaries for each year, personal reflection, the progress reports and assignment feedbacks in addition to the raw data from the participant interviews.

It was important for me to follow the ethos of the doctorate course in carrying out my research. Whilst the counselling psychology course has taught me to become a practitioner scientist it also has strong humanistic underpinnings. In order to carry out research to identify maintained weight loss in individuals with severe obesity it felt appropriate to go directly to the participant. By obtaining data directly from the

individual this allowed a bottom-up approach to producing a substantive theory that was grounded in the participant's thoughts and feelings.

Research Dossier

THE EMERGENT SELF: A THEORY OF WEIGHT LOSS MAINTENANCE

By Carol Cullen

The Foresight Report, 2007 suggests that by 2050, 60% of males and 50% of females will be clinically obese. The consequences of such a rise are a serious concern for the government, healthcare systems and the individuals. Obesity can threaten the individual's mental and physical health and quality of life. For the person living with the classification of severe obesity the frequency and severity of comorbidities make weight loss increasingly difficult. Whilst short-term interventions in treating obesity are successful, long-term maintenance of weight loss shows limited success.

The aim of this research was to develop a substantive theory to explain maintained weight loss. The inclusion criteria selected participants who began their intentional weight loss from a B.M.I. of 35 or above, reached their goal weight and maintained this weight loss for at least one year. Seven semi-structured interviews were carried out and analysed using Charmaz's (2006) grounded theory approach.

A substantive theory of 'Emergent Self' was developed which explained participants' views and feelings of their process of maintained weight loss. The theory was developed from seven categories; 'Normalizing', 'Controlling', 'Isolating', 'Seeking', 'Gaining', 'Analysing' and 'Choosing'. 'Emergent Self' was the core category as it was the most pervasive theme expressed by participants.

Findings suggested that as the participants experienced a process of psychological awareness within a favourable environment their reliance upon food for emotional avoidance reduced. The environment provided; hope for recovery, identification with others, openness and honesty to share, self-acceptance and access to a non-judgemental supportive community of like-minded individuals. The participants facilitated a life-long way of achieving maintained weight loss. These findings can be used to inform future weight management programmes.

Chapter 1- Introduction

1.1 Clarification of Terminology

The aim of this research is to explore how weight loss is maintained by the individual. This achievement was particularly significant in this study as it is focused on individuals who have, in the past, had a high Body Mass Index (B.M.I.) of 35 or above, defined as Class II (obese) to Class III (severely obese) (National Institute of Clinical Excellence, [N.I.C.E.] 2004). This study will discuss many aspects of maintained weight loss; the definitions of the main terms used in this work are detailed below:-

- Obesity in its simplest definition can be stated as the abnormal or excessive accumulation of adipose tissue, resulting from a state of imbalance between the intake of calories versus calories expended. The consequence of which may negatively impact an individual's physical and mental health.
- For the purpose of this study the terms overeating, binge eating and compulsive overeating have been used interchangeably; this approach has been reflected by the participants throughout their interviews. Binge eating is the only form of eating disorder within the Diagnostic and Statistics Manual V (D.S.M. V, 2013) that often results in severe obesity (Binge Eating Disorder, [B.E.D.] (N.I.C.E., 2004)). For the purpose of this study, when reference is made to the N.I.C.E. (2004) guidelines for the treatment of B.E.D., the term B.E.D. will be mentioned so that it is not confused with the N.I.C.E. (2014) guidelines for the treatment of obesity. Other eating conditions that result in severe obesity for example; compulsive eating are not classified as a disorder but may come under 'atypical eating disorders' in the D.S.M. V, 2013.
- The World Health Organisation (W.H.O.) (2015) defined the level of excessive fat deposits by using an international classification of body mass index

(B.M.I.) for an individual's weight. The B.M.I. is calculated by dividing weight in kilograms by the square of the height in metres (kg/m^2). This estimate provides an indication of whether an individual is classified as underweight B.M.I. <18.5, overweight B.M.I. ≤25, or obese B.M.I. ≥30 (N.I.C.E., 2014). B.M.I. is an estimation of an individual's body fat ($kg/m^{2)}$ not an exact calculation, therefore waist circumference, muscle density and a clinician's general observations need to be taken into consideration when estimating weight classification (N.I.C.E., 2014).

- B.M.I. values and waist circumference may not correspond identically across populations due to differing body proportions where fat is deposited. Therefore careful consideration and observation needs to be implemented. N.I.C.E. (2014) have established the need to consider using slightly reduced B.M.I. figures as an indicator for allocating interventions for Asian and other minority ethnic groups due to their higher risk of Type 2 diabetes and cardiovascular disease.
- Within research literature a general consensus has been generated for an acceptable definition of maintained weight loss. Research literature proposes that when an individual loses at least 10% of their original weight and maintains this weight loss for at least one year then this is classed as maintained weight loss (Byrne, Cooper & Fairburn, 2003: Wing & O'Hill, 2001; Zwaan *et al*, 2008). NICE (2014) guidelines identify weight loss maintenance as 5-10% excess body weight loss over a minimum of a 12 month period.

1.2 Introduction

This study will focus on participants who had a B.M.I. of 35 or over and achieved maintained weight loss. Prior to exploring the facilitators and barriers to this achievement, it is important to begin by introducing the components of this work. This chapter will commence with the rationale for this study, placing maintained weight loss into context within society. It will also acknowledge the individual at the centre of the research and consider the current government recommendations that directly impact the treatment of obesity. Chapter 2, Literature Review will consider the aetiology of obesity in addition to the theoretical perspectives attributed to weight management. This is to help form a deeper understanding of the efficacy of government recommendations to current interventions and to identify any gaps herein. The critique of studies pertinent to maintained weight loss will help to demonstrate these gaps and identify where future research is required. Chapter 3, Methodology and Methods will describe the methodology of the research and Chapter 4 will consider the findings depicted by a storyline of maintained weight loss constructed from the participant interviews. These findings will be discussed in Chapter 5 with regard to their theoretical perspectives and their relevance to present day interventions. Finally, in Chapter 6 there will be a critical analysis of this study and reflexivity.

1.3 Context and Rationale

Obesity is very prevalent in today's society on a worldwide scale, not only affecting industrialised countries but is now impacting individuals in developing countries (W.H.O., 2015). As a result of this growth there is an abundance of experimental research and interventions being generated which are pertinent to each country and

its population (W.H.O., 2015). For this reason this study has focused on obesity within the United Kingdom (U.K.).

The population in the U.K. with a B.M.I. of 40 or over is approximately 1.3 million and it is increasing by 60,000 individuals each year (H.S.C.I.C., 2013). The rise in obesity levels within the United Kingdom have now become a serious concern for the government, healthcare systems and the individuals themselves (Public Health England, 2014). This is due to the poor outcomes for physical and mental health that accompany severe obesity and the associated comorbidities. Compared with metabolically healthy normal-weight individuals, obese persons are at increased risk for adverse long-term outcomes even in the absence of metabolic abnormalities (Kramer, Zinman & Retnakaran, 2013). Obesity increases the chances of serious mental and physical conditions (Must, Spandano, Coakley, Field, Colditz & Dietz, 1999) including; depression (Faith et *al*, 2011), high blood pressure (De Pergola, Nardecchia, Guida & Silvestris, 2011), high cholesterol (Andersen, Kendall & Jenkins, 2003), diabetes Type 2 (Kyrou & Kumar, 2010), heart and kidney disease (Liu, von Deneen, Kobeissy & Gold, 2011), stroke (Toss, Lindahl, Siegbah, & Walletin, 1997), respiratory disorders (Jubber, 2004), and mobility limitations (Vincent, Vincent & Lamb, 2010). The frequency and severity of comorbidity increases further for those individuals living with the classification of severe obesity, making weight loss increasingly difficult through poor mobility and a higher risk of mortality (N.I.C.E., 2006).

Obesity levels within the U.K. have increased to such an extent that in England, N.H.S. England (2014) wants government investment for obesity prevention and

public health information. This is in an attempt to curtail what it sees as the avoidable illness of individuals and financial strain on the National Health Service (N.H.S., 2014). Obesity is becoming a serious concern for British society with obesity figures obtained in 2012 by Public Health England, (2013b) which showed that around 62% of adults were overweight or obese (67% of men and 57% of women). A future prediction by an independent government report indicated that by 2050 60% of adult men, 50% of adult women and 25% of children will be obese (Foresight, 2007). This brings a risk of producing a generation who may die before their parents and highlights an urgent need for change (Foresight, 2007). Although the rate of increase in those with obesity has slowed down, the rate of individuals with morbid obesity is still increasing (Public Health England, 2013a). This emphasizes the necessity for establishing a framework to help individuals with obesity as well as creating a healthier future for society in general. In recognition of the growing number of individuals now affected by obesity, a recent ruling by the European Court of Justice has established that individuals who are obese should be protected by disability laws within the workplace (A.C.A.S., 2014). This law will be enforced if an individual's obesity affects their ability to carry out their work (A.C.A.S., 2014). Whilst society adjusts to individuals with obesity, the implementation of wide scale factors contributing to the amelioration of this condition appear limited (National Obesity Observatory [N.O.O.], 2009).

As a consequence of the rise in obesity there is now an urgent need for successful interventions to be identified in respect of long-term maintained weight loss. As a means of tackling obesity the Government have published a Five Year Forward Plan (2014) which states how the National Health Service (N.H.S. England, 2014) needs

to change its strategies in the prevention of obesity. The biggest change is that rather than putting the majority of funding in prevention, the N.H.S. now needs to focus on the increasing numbers of individuals with obesity. The government state that the N.H.S. is now spending more money on bariatric (obesity) surgery for obesity than on intensive preventative lifestyle interventions programmes (N.H.S. England, 2014). The proposal from the government is to move towards specialist local centres, whilst recognising that England is now too diverse for a 'one size fits all' care model. This indicates that a generic intervention for delivery at all specialist centres may be inappropriate (N.H.S. England, 2014). Whilst specialist centres sound a positive advancement in treating obesity, more research is required to focus on the provision of treatment within the specialist centres. Presently the evidence for the efficacy of long-term interventions for maintained weight loss is limited (Wing & Phelan, 2005; Wadden & Butryn, 2003).

Research for long-term weight loss seems to be focused mainly on individuals who are classified as overweight or obese, with the majority of research using a nomothetic approach. A nomothetic approach is essential when trying to obtain large amounts of data on broad areas. I felt that in order to obtain detailed insight into what helped individuals achieve their maintained weight loss; an ideographic approach would achieve this. The scarcity of research, particularly qualitative research in the field of maintained weight loss for individuals with severe obesity, influenced the decision to apply this methodology in the present study. Another influence was my personal perspective as a counselling psychologist in training. I have had the privilege to begin to understand and gain deeper insight into how individuals think and feel about many aspects of their lives. Individuals are experts

in providing information on themselves. This insight has brought with it the knowledge of how so many people struggle with a variety of life events. These events impact some people so significantly that they adopt a means to help them manage day to day. They often choose what are seen by society as positive strategies, for example they may immerse themselves in work, learn new hobbies, exercise, drink alcohol, smoke, gamble, under eat or over eat. All of which are accepted by western society as a norm but can become less socially acceptable when taken to the excess and ultimately become damaging to the body and mind or society. During my experience of working in the field of mental health I found that by addressing the underlying cause for their dependency an individual can often begin to understand that they are able to manage independently. As the individual's own belief in themselves and their ability to manage grows they naturally reduce their chosen form of dependency/coping strategy. I acknowledge that this is only one perspective of overeating from a field of many but it provides insight into my perspective and clarifies in part why this present research methodology is qualitative. This qualitative bottom-up approach is also in keeping with the government's legislation which states it wants to put the patient at the heart of everything they do, creating a person-centred approach to the services which are designed around the individual's needs, aspirations and lifestyle (Department of Health, 2009, N.H.S. England, 2014).

Overeating to the degree that an individual is unable to stop even when their life depended upon it appeared to be something that was beyond their control. This is why it felt logical to begin with an individual who had been in a similar position with regard to overeating to the extreme that their physical and psychological wellbeing

are put at risk. The difference for the participants in this study was that they managed to not only lose weight but maintained their weight loss for at least one year, for one participant 18 years. Using qualitative research allows an ideographic perspective to be obtained which explores the social constructs and meanings that the individual places on maintained weight loss. This detailed research is considered essential due to the lack of consistently effective interventions available into achieve maintained weight loss, particularly for those with a B.M.I. of ≥35.

1.4 The Individual behind the Condition of Severe Obesity

This research ultimately aimed to improve interventions for those individuals who feel that they are trapped by their condition and who feel that they have no alternative but to proceed to surgical intervention. By providing further research in the form of a substantive theory it is hoped to contribute towards interventions for maintained weight loss. It is important to clarify that not all individuals who have a high B.M.I. wish to lose weight or need to seek any medical assistance. These individuals may not have any comorbidity, have a good quality of life and they may feel positive about themselves; indicating a wish to focus purely on their health rather than their weight and feeling that size is irrelevant if you have mental and physical health.

This study explored how individuals changed from being someone who has eaten excessively to the extent that they experience physically and/or psychological ill health, to achieving maintained weight loss. While considering this overall aim, this work also hoped to provide the reader with an understanding of just how devastating severe obesity can be for the individual, bringing a feeling of powerlessness to their lives. For many people who have not experienced severe obesity or know anyone

with this condition, it may be very difficult to comprehend (Puhl & Heuer, 2009). They may hold the view that it is the individual who is knowingly putting themselves in this position and can therefore reverse what they are doing; yet the same could be said for anyone who takes any substance to excess (Liu et *al*, 2010). Imposing judgement on individuals who are obese not only limits flexibility of thinking but also an understanding of the individual and their condition (Puhl & Heuer, 2009). By carrying out semi-structured interviews I hoped to gain insight into the participants' lives, their thoughts and feelings around obesity and maintenance with the aim of identifying a grounded theory that could be used in present day interventions for maintained weight loss.

The excessive use of a substance or a behaviour is not unusual in society; alcoholism, anorexia, gambling, hyper-sexuality, over-exercising, over-working, excessive internet use, gaming, self-harming, drugs; prescription or illegal, steroids, laxatives, etc. It is important to identify why these excesses have manifested to the degree that the individual feels that their mental and physical wellbeing are negatively affected. By identifying what the substance or behaviour means to each individual it may be possible to manage it more effectively. The treatment for many of the above is to abstain from the substance completely which is not possible with food and therefore treatment is potentially more complex but just as necessary. Greater research and knowledge about the reasons behind the behaviour will contribute to a greater understanding of the use of the substance and identify appropriate interventions for the treatment of severe obesity.

This work will begin by guiding the reader through the current recommendations established by the government for addressing obesity and severe obesity within the UK and the efficacy of these interventions

1.5 Current National Recommendations for Obesity Management

Currently the national recommendations for interventions to treat individuals with obesity centre on maintaining a calorie-controlled diet and at the same time increasing physical exercise (N.I.C.E., 2014). A meta-analysis of nutritional and behaviour-focused weight management interventions suggests that diet and exercise remain largely unsuccessful long-term with half (Wadden & Butryn, 2003) to three quarters (Anderson, Konz, Frederich & Wood, 2001) of obese participants usually regaining their lost weight within five years. Individuals are finding it difficult to sustain their lost weight. It is important to focus not only on the treatment but on encouraging uptake and continued attendance on the treatment programme which all contribute to weight management. Further research into the barriers and facilitators to maintained weight loss may provide answers.

The targeted delivery of appropriate interventions within the N.H.S. is underpinned by guidelines from the National Institute for Clinical Excellence (N.I.C.E., 2004). The lack of knowledge and recommendations for obesity related disorders is evident when looking at the limited N.I.C.E. (2014) guidance for clinicians. The treatment for atypical eating disorders recommends identifying the clinical presentation that most closely resembles anorexia nervosa, bulimia nervosa or binge eating disorder (N.I.C.E., 2004). This shows a lack of knowledge in treating atypical eating disorders. N.I.C.E. (2004) offer guidance on the interventions for binge eating

disorder (B.E.D.). B.E.D. was recognised in 2013 as an independent classification in the D.S.M.-V (APA, 2013), having previously been classified as 'eating disorders not otherwise specified' (American Psychiatric Association, 1994). Binge eating is defined as having episodes of excessive eating within a short space of time and accompanied by a feeling of loss of control for the individual (N.I.C.E., 2004). Shaw, O'Rourke, Del Mar & Kenardy, (2009) identified that B.E.D. and compulsive overeating are both more common in women than in men, which is important when considering interventions. The recommended treatment for B.E.D. includes physical and psychological treatments as well as pharmacological interventions (where appropriate) (NICE, 2004). At the same time as advising these treatments N.I.C.E., (2004) also recommend that patients are informed that psychological treatments for B.E.D. have a limited effect on reducing body weight. The impact of these recommendations places a negative connotation on the treatment before the individual has even started them. N.I.C.E. (2004) guidelines recommend that individuals with obesity are referred to a lifestyle weight management programme if one is available. N.I.C.E. (2004) suggest making clear to the patient that no programme holds a 'magic bullet' or can guarantee long-term success. This statement could be demotivating for an individual beginning a weight management programme or psychological intervention. The lack of clarity and belief in the interventions for severe obesity indicates a need for greater research in this area.

Another intervention recommended by N.I.C.E. (2014) is weight loss/bariatric surgery which is available for individuals with a B.M.I. of ≥ 35 with comorbidities. Surgery, in general, carries potential risks, and it is the responsibility of the physician to evaluate the risks for bariatric surgery against risks from being severely obese. The use of

bariatric surgery is presently recommended (N.I.C.E., 2014) in the UK as an effective intervention for individuals who meet the following criteria;

- BMI of 40 kg/m^2 or more, or between 35 kg/m^2 and 40 kg/m^2 and other significant disease (for example, Type 2 diabetes or high blood pressure) that could be improved if they lost weight.
- All appropriate non-surgical measures have been tried but the person has not achieved or maintained adequate, clinically beneficial weight loss.
- The person has been receiving or will receive intensive management in a tier 3 service.
- The person is generally fit for anaesthesia and surgery.
- The person commits to the need for long-term follow-up.

Many patients consider surgery as their only hope, which is understandable if options are limited for successful weight loss interventions. Weight loss surgery patients turn to the medical profession and surgery as a means to control their body weight, lacking belief in themselves (Engström , Wiklund, Olsén, Lönroth, & Forsberg, 2011; Newhook, Gregory & Twells 2013), and often describe surgery as a transformation or a rebirth (Bocchieri, Meana & Fisher, 2002; Throsby, 2007). Such emphasis places great pressure on the medical profession to provide a means of treating this condition.

1.6 Potential changes to Government Recommendations for Obesity Management

Presently bariatric surgery is used as a means to treat people who have potentially life-threatening obesity (N.I.C.E., 2014). Surgery of any kind presents a degree of

risk and bariatric surgery is associated with greater risk of adverse out-comes and is therefore generally reserved for patients with more severe disease (Apovian, Garvey & Ryan, 2015). With the cost for treating obesity increasing, particularly with regard to treating the comorbidities, there is a greater pressure to reduce both comorbidities and cost. Consideration is currently being given by N.I.C.E., (2014) to lower the threshold for weight loss surgery to a B.M.I. of 30 for people who have recently been diagnosed with Type 2 diabetes. This will mean that more resources will be given to treating the symptom rather than investing in understanding the cause for the condition and how to prevent and if necessary treat it.

Research on maintained weight loss in individuals with severe obesity has mainly focused around individuals who have had weight loss surgery; reported outcomes are mixed (Owen-Smith, Donovan & Coast, 2014). Ogden, Holywood and Pring (2015) state that bariatric surgery is currently considered the quickest and most successful intervention for weight loss for individuals with severe obesity. However bariatric surgery is a major surgical intervention with a risk of significant early and late morbidity and of perioperative mortality (Jaunoo & Southall, 2009). There are numerous contraindications to bariatric surgery some of which include significant chronic obstructive airways disease, non-compliance of medical treatment and significant psychological disorders (Colquitt, Pickett, Loveman & Frampton, 2014). Even considering the risks involved with surgery, it is considered to be a means of managing severe obesity and to decrease suffering by reducing the individuals' comorbidities and potentially gaining an increased quality of life (Fornitano & Godoy, 2010).

Meta-analysis on random controlled trials for the effectiveness of bariatric surgery has proved difficult due to a lack of consistently reported adverse events, and re-operation rates, in addition to the questionable quality of each study's design (Colquitt *et al,* 2014). Colquitt *et al.* (2014) noted that there is a need for a systematic way to record adverse outcomes from bariatric surgery in addition to the number of patients who underwent operations and the number of mortalities resulting from surgery. The inconsistency in reporting outcomes does not provide a clear indication of how successful bariatric surgery is, particularly with regard to long-term follow-up for weight maintenance. Considering the lack of clarity on the short-term and long-term outcomes for bariatric surgery, it is likely to remain a significant intervention for severe obesity. By identifying what facilitates maintained weight loss following non-surgical interventions by focusing directly on the individual's perception of this process this study may also be able to contribute to long-term maintenance and lifestyle change following bariatric surgery.

Historically the medical profession has been seen as an authority to turn to for a cure of an illness or to prevent physical suffering. It has responded by finding the pathological aetiology and resolved the illness through medication or surgery. Due to the lack of effective medication to manage weight reduction, bariatric surgery remains the intervention that quickly reduces excess body fat; making surgery the treatment for severe obesity. It is reported that weight-loss surgery is used as a last resort to treat people who are dangerously obese. However consideration is already being given to reduce this threshold. Presently it is recommended that surgery is carried out only when all other treatments have been tried and failed (NICE, 2014).

If there are limited alternative treatments available, then the numbers of bariatric operations are likely to increase.

It is important to question whether surgical reliance is becoming the norm in the absence of successful non-surgical, long-term interventions to achieve maintained weight loss. Whilst at the same time recognising that surgical procedures are pivotal in providing a vital, life-saving intervention in certain circumstances.

1.7 Conclusion

This chapter has considered the recommendations provided by N.I.C.E. (2014) guidelines in the management of severe obesity which revealed a lack of belief in non-surgical interventions for providing long-term benefit. At the same time as recommending bariatric surgery despite the risks and potential contraindications to the severely obese individual, consideration is being given to lowering this threshold. While the government states that it does not want a 'one size fits all' approach to treatment (N.H.S. England, 2014), evidence appears to the contrary. With limited evidence supporting non-surgical long-term interventions for individuals with severe obesity, bariatric surgery will continue to be the treatment of choice for individuals meeting the changing criteria.

Having considered the current national recommendations for treating obesity, it is also important to review the aetiology of obesity, as well as the theoretical perspectives underpinning obesity which contribute to the development of interventions. The strengths and limitations of the studies that have contributed to maintained weight loss will also be considered.

Chapter 2 – Literature Review

2.1 Introduction

The previous chapter provided background on the obesity crisis that is quickly becoming one of the main concerns for the N.H.S., government and the population in the UK. It has also provided a degree of insight into the nationally recommended guidelines for treating obesity and highlighted the necessity to identify successful strategies, particularly with regard to severe obesity. With reference to recent research, this chapter will first consider the theoretical explanations of weight gain, and second outline evidence regarding the effectiveness of weight loss interventions.

Relevant literature was identified by undertaking a search via EBSCO Host of PsychINFO, CINAHL Plus and MEDLINE, in addition to The Cochrane Collaboration publications, Google and Google Scholar. Specific search strategies were derived using key words initially, for example morbid obesity, severe obesity, obesity, weight management, maintained weight loss etc. Abbreviations would also be used obes*, morbid* etc. Citations from the papers retrieved in this initial search were also referred to. For the purpose of the literature search this study has included any empirical study which examined weight loss maintenance. The lack of available research regarding severely obese individuals, aside from bariatric surgery, necessitated the inclusion of literature which focused on individuals who have been overweight and obese. Studies on obesity using qualitative methodology were also limited particularly in relation to severe obesity. This highlights the importance of this study's work in contributing to further qualitative studies on the individual's perspective of severe obesity to maintained weight loss. The studies reviewed involved individuals from both clinical and non-clinical populations, focusing on the most up to date studies first.

2.2 Aetiological and Theoretical Explanations for Obesity and Weight Loss

The aetiology of obesity is held to be multifactorial, primarily caused by complex interactions between human behaviour, the environment and an individual's genetic disposition (N.O.O., 2010). Research into the aetiology of obesity is abundant, diverse and inconclusive which highlights the difficulty of identifying solutions in both prevention and intervention. This section will provide an overview but this is by no means exhaustive and is presented as an illustration of the causes of obesity. Consideration is given here to the aetiology being one of a biological, behavioural and psychological perspective.

2.2.1 Biological Aetiology

Specific genes have been identified that predispose particular individuals to gain weight when surrounded by an obesogenic environment where rich high calorie foods are easily available to individuals (Owen-Smith et *al*, 2014; Lenzi, Migliaccio & Donini, 2015). Being in an environment that has an abundant supply of high-calorie, rich food that is readily available to most individuals can be seen as detrimental to someone who is biologically drawn to consume such foods. Having a genetic predisposition to obesity is considered to be a contributory factor but does not solely determine obesity (Wilding, 2011; Nammi, Koka, Chinnala & Boini, 2004). Many people may originate from a long line of descendants who have been overweight or obese and whilst a genetic factor may be an element of their obesity, this may also be explained as a learned behaviour dependent upon cultural, environmental or emotional factors (Collins & Bentz, 2009).

It has also been evidenced that some individuals may have a deficiency in a biological response to satiety or incurred damage to a part of the body which is responsible for controlling feelings of hunger and satiety (Hellstrom, 2013; Arafat et *al*, 2013). Medication may also affect satiety or induce cravings for increased food consumption. These medications can be taken as a result of having a pre-existing condition which then results in obesity or conversely the individual may be obese prior to having a medical condition and taking medication.

2.2.2 Behavioural Aetiology

Lifestyle and behaviour choices ultimately influence the way individuals treat their bodies and determine overall health. It is difficult to ignore the impact that living in a modern society has on obesity, with the abundant availability of rich, high-energy food and a reduction in the need for increased energy expenditure. With the knowledge that a sedentary lifestyle and poor eating habits can ultimately result in health complications, one of which is obesity, it is important to establish a healthy lifestyle. Sedentary behaviours in adults are affected by age, gender, occupation, weight status and socio-economic conditions (Department of Health, 2015). A healthy diet and increased exercise are considered to be the basis to weight loss yet attrition rates are high on weight management programmes implementing these (Grave, Suppini, Calugi & Marchesini, 2006; Teixeira et al, 2004). The reasons for this attrition call for further investigation.

2.2.3 Psychological Aetiology

There are bi-directional associations with obesity and mental health (N.O.O., 2010). Obesity has been linked to depression (Cunningham et *al*, 2012), anxiety disorder

(Toups et *al*, 2013), psychosis (Wilding, 2011), bipolar disorder (McElroy & Keck, 2012), and post-traumatic stress disorder (Pagoto et *al*, 2012). Medication is a prevalent intervention with many of the above conditions, which may be responsible for weight increase. A bi-directional association between obesity and depression is consistently reported in the literature. An individual's propensity to be isolated and sedentary when experiencing depression, coupled with effects of medication creates a cyclical condition that is difficult for the individual to break. A systematic review of longitudinal studies evidenced that obese individuals had a 55% increased risk of developing depression, whilst depressed individuals had a 58% increased risk of becoming obese; both of which need to be considered when treating obesity (Luppino et *al*, 2010).

There are various theories to why obesity and poor mental health are so prevalent. For individuals with severe obesity, the pathway to having poor mental health can result from; increasing medical conditions associated with poor mobility and reduced quality of life. The consequences of which may impact the individual in many ways, for example binge eating, isolation, depression and low self-esteem (Butland et *al*, 2007). Obesity has also been linked to individuals who have experienced insecure attachment (Mazzeschi et al, 2014) and having a traumatic childhood (Hughes, Power, Fisher, Mueller & Nicklas, 2005). As a consequence of which food is used as an emotional stabiliser. Emotional eating has been connected to obesity; where individuals use food as a means of coping with various kinds of psychological stressors (Buckroyd, 2011). Individuals are known to crave high energy foods, high in saturated fat and sugar, which consumed over time, will result in obesity (Sims et al, 2008).

2.2.4 Summary

This section on aetiology has shown that there is potential for a complex interplay of different biological, psychological and behavioural determinants (N.O.O., 2010) to contribute to obesity. Individual differences appear to play a part in determining a person's response to food which suggests that a generically determined intervention may not be suitable for every individual. Treating obesity may require an individualistic response particularly if complex aetiologies are present.

It is of significant importance to remember that obesity is itself primarily a preventable condition. When we consider that people are spending a lifetime experiencing obesity and the negative consequences it brings to the individual, this in itself emphasizes the need for the government, society and researchers to identify prevention and intervention action.

2.3 Theories and Perspectives of Weight Management

This section considered the theories of weight loss and the perspectives that they brought to weight management. Any barriers that may be present to an individual wishing to lose weight were also considered. Understanding the different theoretical perspectives behind weight increase and loss, allows a deeper understanding of how the individual may be affected in weight management. Consequently greater theoretical knowledge combined with the individual's perspective provides insight into what facilitated the individual to achieve maintained weight loss. Caution needs to be taken when acknowledging the theoretical perspectives because they may not fully explain the individual's perspective of maintained weight loss. By combining

theory and participant experience this may highlight new areas where theory does not adequately depict experience.

2.3.1 Eating Behaviours

The behaviour pattern of each individual is an important element to consider in identifying an approach to helping the individual in their weight management. People with severe obesity no longer use food purely as nourishment to survive; their behaviour towards food has changed (Hou et al, 2011). The individuals are being motivated by other reasons than to satiate hunger. By considering the possible explanations for their behavioural patterns it provides insight into how an individual uses and responds to food. This is only one aspect of many to consider when determining an appropriate intervention.

2.3.2 Social Environment

It is difficult to investigate an individual's eating behaviour without considering their milieu. One of the main reasons that individuals are getting heavier is due to their increased calorie consumption. An individual's relationship with food is important and food is treated very differently by each individual; it may be used as an indulgence on special occasions, purely as nutrition or an emotional dependency (Sims et al, 2008). Many cultures have a tendency to be focused around food particularly on cultural holidays and celebrations where food is at the very centre. Being surrounded by an abundance of high-calorie foods creates an added difficulty for those individuals who are sensitive to external eating; eating food irrespective of hunger cues (Snoek, Engels, van Strien, & Otten, 2013). Being aware of the

reasons people are overeating is essential in order to help identify how an individual can alter their relationship to food.

External Eating

Individuals who engage in external eating are found to be impulsive and have attention bias to food cues whether or not they feel hungry, which creates obstacles in an obesogenic environment (Hou et al, 2011). Schachter's (1971) externality theory of obesity regards individuals who are obese to be hypersensitive to external food-relevant stimuli, while being hyposensitive to internal signs of hunger and satiety. These internal signals can become overridden as food intake increases. In addition to the hypersensitivity to external foods, Nijs, Franken and Muris (2009) identified through the use of neurological mapping of the brain's motivation system that high external eaters demonstrate an enhanced processing of food-related information compared to low external eaters. This created strong cravings in response to the exposure of food and a loop reward system that encouraged overeating. Similar activation of the brain area has been identified in substance dependent patients to indicate cravings (Field, Munafo & Franken, 2009). This highlights the difficulty for individuals trying to reduce food consumption whilst also being hypersensitive to external food cues. This also provides a tentative link to obesity and addiction. These are barriers to weight loss and maintenance and the ability of individuals to overcome such barriers were considered in this present study by exploring their relationship with food.

Restraint theory

Significantly reducing food consumption is considered a key component of restraint theory where an individual uses cognitive restraint. This has been shown to be particularly difficult for individuals to do when reducing and/or changing their dietary

intake (McGuire, Wing, Klem & Lang & Hill 1999). This emphasizes the importance of identifying how individuals who have maintained weight loss managed to succeed in reducing their intake through restraint. This perceived failing from those who are not successful in reducing their food intake can result in feelings of negative self-image, poor self-esteem and depression (Miller & Jacob, 2001). This again recognises the mental health implications for individuals who do not succeed in weight loss.

Buckroyd & Rother (2007) question the viability of using willpower alone to restrict diet. They state that it is too difficult for most people to maintain in the long-term and that short-term results reporting successes can be misleading without confirmation of maintained loss after at least one year. Stroebe, van Koningsbruggen, Papies and Aarts, (2013) present an alternative perspective to the goal conflict model used in many weight management programmes. The perspective found that when attempting to adhere to setting goals for weight loss the majority of individuals were in conflict between eating enjoyment and weight control. Only a minority of maintainers were successful in using self-control to override their impulse for rich calorific foods; although no definitive reasons were found for their success it was felt to be attributed to past success in using self-control and losing weight and therefore developing an association with high calorie foods and weight control thoughts. Stroebe et al, (2013) recommended using implementation intentions which entail individuals responding to a behavioural plan when tempted by food or remembering control-related words but further research in this area is required.

The success of using restraint theory in reducing calorie intake may be dependent upon individual differences and therefore may not work for everyone but further research into how and why individuals do succeed may help others who have not been able to (Dodd, Smith & Bodell, 2014).

Repeated dieting

Diets seem a good solution to the individual who cannot significantly restrict or regulate their intake of food; they provide a certain proportion of healthy food at a set time each day and stay within a calorie count. However, diets can encourage the individual to respond to external cues of eating, and ignore the internal cues, which can ultimately be detrimental to long-term weight maintenance (Miller & Jacob, 2001). Insensitivity to internal cues and ignoring hunger may progress to insensitivity to other internal cues. This may result in a greater reliance on external eating cues which often results in a pattern of eating more than is required and putting on more weight (Fairburn & Brownell, 2002). Another perspective to non-adherence of diets was identified by Van Buren and Stinton (2009) who suggest that the failure to maintain a new diet is due to the instinctive biological drive that individuals have - to eat to survive. This works against trying to reduce food consumption and can result in causing emotional distress for the individual as they are fighting an innate behaviour and failing. It is questioned whether fighting a biological drive to eat can be considered for the severely obese individual because they are having more than enough food to satisfy hunger. This may indicate that internal cues have been overridden. These examples of behavioural patterns of responding to food begin to highlight a more complex understanding of the processes involved in what one might deem to be a simple process, such as eating. Theoretical explanations of eating behaviours allow insight into the individual's use of

food, to identify more adaptive behaviours. Individuals who consistently diet and use restricted eating can risk masking their sensitivity to internal cues by unhealthy learned behaviours therefore hindering any positive eating pattern (Miller & Jacob, 2001).

The majority of research has focused on why participants fail to achieve maintained weight loss which while highlighting what not to do it does not provide positive answers.

2.3.3 Energy Expenditure

The recent NICE (2014) guidelines for treatment of obesity recommend encouraging individuals wanting to lose weight, to begin or increase their exercise levels. Exercise alone without a healthy or reduced diet has been shown to have positive benefits even when no weight is lost; reducing rates of coronary heart disease, hypertension and non-insulin dependent diabetes mellitus (Powell & Pratt, 1996). Diet accompanied by exercise revealed significant weight loss but this was only moderately sustained over one year (Finkler, Heymsfield & St-Onge, 2012). Many individuals cannot sustain keeping to a reduced calorie diet and increased exercise regime and some individuals fail right from the start. Finkler et al, 2012 recognise that people are unable to sustain an exercise regime long-term but their study does not questioned why this occurs. Spring et *al*. (2013) recognised that technology in weight loss, for example using mobile telephone apps to monitor calorie intake and activity expenditure, can be useful for some individuals who like to work independently and gain reward knowing that they are achieving by having their success rate monitored.

Further research is required into identifying why individuals are unable to adhere to a long-term exercise regime because losing weight and then being unable to maintain that lost weight can negatively impact the individual's mental wellbeing which increases if this is established as a pattern of behaviour (Shaw, Gennat, O'Rourke & Del Mar, 2006).

An alternative approach to the present medical model of a reduced diet and increased exercise has been suggested by Health at Every Size (H.A.E.S.) which proposes that, if diet restrictions and barriers to activity have been removed, the individual will develop healthier eating patterns and activity patterns which will lead naturally to a healthier body weight (Miller & Jacob, 2001). Treatment then should focus more on removing negative body image and the focus around weight and look to an improvement in mental health, quality of life and self-acceptance. The model proposes that health is a result of behaviours that are independent of body weight, which is in complete contrast to the present recommendations by the medical model (Miller & Jacob, 2001). The H.A.E.S. model does not evidence weight loss whilst participants are on the programme but has demonstrated that with time participants can maintain a stable diet with weight loss because they are more motivated to do so of their own volition (Sbrocco, et *al*, 1999). One drawback is that the time involved for the individual to identify an enjoyable healthy diet and exercise regime may be too great in a time-limited, outcome orientated health care system that has a need to evidence weight change to reduce physical ill health. Bacon and Aphramor (2011) found that the H.A.E.S. approach has shown to provide improvements in physiological measures, health behaviours, and psycho-social outcomes, therefore obtaining all round benefit for the individual. This research has been carried out on a

small scale and further research could determine greater efficacy. Research from N.O.O. (2010) supports the use of psychological interventions with diet and exercise which were found to provide more successful weight loss management.

The positive effects of exercise have been found to boost oxytocin in the body which is found to suppress cortisol production and so reduce stress. Therefore if the barriers can be overcome or an approach that enables individuals to exercise and eat more healthily can be sustained then the physical and psychological benefits are soon evident. It is acknowledged that once a positive behaviour change has become established, the individual is more inclined to contribute positively towards weight loss maintenance (McGuire et *al*, 1999).

Both the medical model and the H.A.E.S. model agree that healthy eating and an increase in exercise are the required goals for better mental and physical health. The difference is that they approach it from differing perspectives. A change of approach may be what facilitates long-term maintained weight loss.

Further barriers have been identified with regard to achieving increased levels of exercise; Lewis et *al*, (2011) found that individuals with severe obesity may have difficulty with mobility as well as being reluctant to exercise in a public environment due to the stigma and emotional distress they experienced. This highlights some of the obstacles and potential barriers presented in implementing effective weight management, particularly where exercise is concerned for individuals with severe obesity.

2.3.4 Psychogenic Theory of Obesity

Buckroyd & Rother's (2007) research focuses on individuals who are very obese stating that they tend to have difficulty coping with everyday stress or present/past traumas in their life. The individual may find comfort through food consumption which becomes their coping strategy in a similar way to developing a dependence on using for example, alcohol or nicotine. This emotional distress they experience then creates a dependency upon food which is difficult for them to withdraw from. This difficulty to adjust is evident in some individuals after having bariatric surgery; individuals were unable to manage psychologically and had to continue to use food as a coping strategy or change to an alternative substance (Owen-Smith et *al*, 2014). Green, Engel & Mitchell, (2014) identified that an individual's use of alcohol increased post bariatric surgery. Buckroyd (2011) stated that eradicating the use of food or an alternative substance as a coping mechanism will not be successful unless an alternative, positive strategy is found. For the individual who has created such a strong dependency on food and who is then asked to eat a healthy, reduced calorie diet and increase their physical activity they are going to find it difficult to maintain. The individual's coping strategy has not been addressed and they do not always receive the psychological help they need to resolve the underlying issues.

In treating obesity Buckroyd (2011) has a similar approach to the H.A.E.S. model by looking to the individual's mental health first. She suggests that clinicians should focus on developing the individual's emotional intelligence, self-esteem, body esteem, relationships and self-soothing so that they can cope when food is reduced. These issues are addressed to some extent within the N.I.C.E. (2004) guidelines for treating B.E.D. using dialectical behaviour therapy-binge eating disorder [D.B.T.-

B.E.D.] (N.I.C.E., 2004) which focuses on many of these aspects. It is unknown how widely D.B.T. is used for treating B.E.D. and whether it is used at all for treating all severe obesity conditions. This information would be beneficial in understanding whether this approach is successful throughout the N.H.S.

Another theoretical perspective regarding obesity explains that binge eating is motivated by a wish to escape from self-awareness. Heatherton & Baumeister (1991) identified binge eaters as having very high standards and being extremely sensitive to the perceived demands of other people in their lives. They experience emotional distress, usually anxiety and depression if they feel they are not doing as well as they feel is expected of them. To escape from the emotional distress they are experiencing they use food as a distraction to feelings of failure and other negative thoughts about themselves. This behaviour then results in further weight gain and the individual then experiences a vicious cycle negotiating self-blame, failure, shame and distress again turning to food for comfort (Klein, 2004: Owen-Smith et *al*, 2014; Throsby, 2007). It is possible to see a picture of the individual being on an emotional roller-coaster involving food and relating to food at a much deeper psychological level. The present N.H.S. focus on weight loss detracts from the level of deeper psychological dependency that individuals have on food and as a result the individual is unable to adhere to a diet and exercise programme without obtaining positive mental health.

2.4 Interventions for Weight Loss

The N.H.S. funds current interventions for weight management; these can be located in hospitals, clinics or the community. Further interventions can be found in private,

commercial weight loss programmes. The effectiveness and availability of these interventions will be considered in the management of severe obesity. Additional interventions are the use of bariatric surgery which has been discussed previously and pharmacology which is presently limited in producing a safe effective intervention.

2.4.1 Community and Private Weight Loss Endeavours

Present N.I.C.E. (2014) guidelines advise primary care physicians to refer individuals looking to lose weight to use community services, for example commercial weight loss programmes or volunteering groups for example, gardening or walking groups. N.I.C.E. (2014) also recommend that clinical commissioning groups, health and wellbeing boards, and local authorities should commission lifestyle weight management programmes through the public, private or voluntary sectors in the community or primary care.

Jolly et *al*. (2011) used a randomised control trial to determine success rate and cost effectiveness of lifestyle weight management programmes. The research looked to establish the efficacy of six 12 week, weight loss programmes; Weight Watchers, Slimming World and Rosemary Conley, a group based dietetics led programme, a general practice one to one counselling programme and a pharmacy led one to one counselling programme. They collected the data outcome for each programme which contained a total weight loss at the end of the programme and one year follow-up. All programmes obtained significant weight loss from baseline to programme end yet the primary care based service was reported as being ineffective. The commercial weight loss programmes resulted in greater weight loss at the year-end

weigh in. It is important to note that the research did not compare each programme against the other, it only compared all programmes with the comparator group. As a consequence the programmes differed vastly, for example the commercial programmes ran weekly sessions from 60 – 90 minutes, one of which included the option of an exercise class whilst the primary care programme ran the first session at 30 minutes with follow-up sessions lasting 15-20 minutes. Other considerations to note are the quality of and amount in training for group leaders. For the purpose of this study it is important to note that the participants in Jolly et *al's*. (2011) study were either overweight or obese not severely obese. Considerations to take from this study centred on the use of group sessions for each programme other than the primary care ones which were one to one, because attrition rates for group sessions were low. The commercial weight loss programmes revealed participant follow up at one year was 70.5% showing clear adherence rates to the programmes. The general practice and a pharmacy led one to one counselling programme had high attrition rates which could be attributed to the limited service being provided with regard to session time. Additionally, the staff in primary care had many roles which made booking consistent, weekly sessions difficult. It was noted that the primary care staff did not feel competent in their abilities to facilitate change in the participant's weight. This belief in the efficacy of the programme might be influential with regard to motivating the individuals in their weight loss.

The commercial programmes were run efficiently by informing participants of details; booking them in and engaging them in weekly run sessions with professionally trained facilitators who could help facilitate group cohesiveness. The efficiency of the programme was thought to contribute to adherence rates. Jolly et *al*. (2011) also

found differences between sexes; the men were reluctant to attend the commercial weight management programmes, because it was perceived as a female dominated group. This was overcome by highlighting that other males were in the groups which helped to ensure the participant's attendance to the programmes.

Jolly et *al*'s (2011) research has enabled insight into the importance of the programme leader believing in the success of the programme, providing a service that is efficient in addition to understanding the benefits of group work. The programmes focused on behavioural and cognitive change for the individuals with increased exercise but there was no in-depth psychological perspective facilitated by these programmes. Follow-up data focused on end of programme and one year but did not indicate whether participants were still attending the commercial programme during the time between end of programme and year end as this is likely to influence year end data. This study although it has limitations some of which have been discussed here, it also presents some positive aspects to consider for interventions to achieve maintained weight loss.

2.4.2 N.H.S. Tier 3 and Psychological Services

NICE (2014) guidelines for obesity suggest that individuals should be referred to a Tier 3 weight management programme if;

- their underlying causes of being overweight or obese need to be assessed
- the person has complex disease states that need more specialist care
- they have tried all other forms of treatment without success or if drug treatment (only for a BMI of more than 50 kg/ m^2), a very low calorie meal or surgery are being considered.

It is recommended by N.H.S. England (2014) that the individual will be seen by a multi-disciplinary team to determine which patient pathway they require. It is then recommended that the patient will receive medical, psychiatric, psychological and dietary assistance in addition to exercise advice. Although these are the recommendations, the report also stated that Tier 3 specialised obesity services are variable, with the absence of such services in many areas. The N.H.S. recommendation is that the patient must engage with the service for a minimum of six months but usually 12 - 24 months duration (N.H.S. England, 2014) prior to consideration for bariatric surgery.

The psychological treatments that are recommended by N.I.C.E. (2004) are specifically adapted for binge-eating. They focus on cognitive behavioural therapy-binge eating disorder (C.B.T.-B.E.D.), dialectical behavioural therapy-binge eating disorder (D.B.T.-B.E.D.) and interpersonal therapy (I.P.T.). C.B.T. is an evidence based therapy focusing on changing maladaptive cognitive patterns in order to change an individual's behaviour and emotional state. C.B.T. also looks at the moderation of food intake, modification of negative stereotypes, promotion of acceptance of body size and the encouragement of increased exercise (Fairburn & Brownell, 2002). C.B.T. has shown to have successful outcomes in reducing binge eating (Grilo, Masheb & Crosby, 2012; Rapoport, Clark and Wardle, 2000). This approach focuses on diet and exercise as well as the individual's cognition as an intervention for weight reduction. Although D.B.T. is based on the underlying principles of C.B.T. it is also comprised of mindfulness and acceptance and similarly has evidenced successful treatment of B.E.D. (Glisenti & Strodl, 2012; Roosen,

Safer, Adler, Cebolla & Strien, 2012). I.P.T. is also included in D.B.T. but can be used separately. The overall goal of D.B.T. is to help increase resilience and build a life worth living (Linehan, 2015). The intervention of D.B.T. which looks to change negative behaviour, emotional dysfunctional and cognition as well as work towards improving interpersonal patterns would support the research by Buckroyd (2011) in addressing underlying psychological issues as well as or prior to addressing weight. With these recommendations it is questioned why weight maintenance is not established. The consistency of reporting outcomes for the N.H.S. weight management programmes across the UK were identified as being often poorly evaluated or they are not reported on at all (Logue, Allardice, Gillies, Forde and Morrison, 2014). This makes comparison of the programmes difficult to carry out and therefore any successful programmes are not being utilised for others to benefit from. The study recommends the use of standardised data collection as a means of identifying those successful programmes.

2.4.3 Pharmacotherapy and Obesity

In addressing the barriers to weight loss and its maintenance it is important to be aware of the influence that medication may have on the individual in achieving this goal. Presently two of the three prescribed medications specifically used to treat obesity in the U.K. have been withdrawn due to adverse side-effects; Sibutramine and Rimonabant. Orlistat is the only pharmaceutical medication to directly assist in weight and blood pressure reduction in the U.K. Orlistat is recommended by N.I.C.E. (2014) to help manage obesity yet is known to have frequent gastrointestinal side effects (Siebenhofer et *al*, 2013). Commercial weight loss tablets are available for individuals to buy independently but their efficacy and/or safety is questioned

(Fairburn & Brownell, (2002), and taking them can have negative psychological outcomes for those concerned (Mendieta-Tan, Hulbert-Williams & Nicholls, 2013).

Due to the association with mental ill health and obesity, many individuals who seek to lose weight may be on prescribed psychiatric medication for their mental health disorder. Schwartz, Nihalani, Jindal, Virk and Jones' (2004) meta-analysis identified that psychotropic medication is likely to induce weight gain and as the use of these medications is increased consequently so may weight gain, increasing the risk of obesity. Of particular relevance is the use of selective serotonin reuptake inhibitor (S.S.R.I.) which NICE (2014) recommend to help in the treatment of binge eating disorder. At the same time as prescribing these medications physicians are recommended to inform patients that the interventions have a limited effect on body weight; this seems counterproductive when the patient is reportedly seeking help with weight reduction. Consideration needs to be given to whether the individual's depression is the symptom of obesity as discussed above, and not the cause. There is validity and necessity in treating the symptom first in many situations but in this instance it appears to be counterproductive if obesity was the cause of the depression and medication increases weight. The patient may question this intervention and consequently reduce the belief in their physician to treat severe obesity.

2.5 Barriers to Maintained Weight Loss

2.5.1 Physician's Perspective

Primary care physicians have an important role to play as they are often the first contact that the individual has when seeking help regarding their weight

management. The physician's response is important in engaging the patient in further intervention. N.I.C.E. (2015) recommends that physicians encourage people to develop physical activity and dietary habits that will help them maintain a healthy weight and prevent excess weight gain. This places the responsibility on the physician to act; which may prove difficult if there are limited evidenced successful resources to refer patients to. Mehta, Patel, Parikh and Abughosh (2012) identified that primary care physicians select certain individuals to refer on to the specialist services; those who are referred are the ones who are more in need with a B.M.I. of 40 or above, who have been seen a lot by the physician and who have comorbid conditions. Other patients with obesity are likely to be referred to services in the community (NICE, 2010). The Royal College of Physicians (R.C.P.) (2013) have recognised the need for greater clarity and support for physicians in the treatment of obesity and have requested that more training is provided for physicians around the management of obesity (Phelan, Nallari, Darroch & Wing, 2009; R.C.P., 2013). The R.C.P. (2013) said that the present response by the N.H.S. to obesity treatment is patchy and they suggested providing specialist multi-disciplinary teams as a way forward. These are now being recommended by N.I.C.E. (2014). Presently physicians recommend the simplified energy-in–energy-out explanation of losing weight along with behavioural therapy but research by Owen-Smith et al. (2014) recommends moving towards having more of an understanding of the viscous cycles of on-going emotional distress to weight gain; being overweight, experiencing stigma in society, not accessing facilities, isolation and mental ill health. This approach to a vicious cycle highlights how complex the treatment for obesity is, it also highlights the necessity for further research to obtaining successful interventions.

2.5.2 Psychological Impact of Societal Stigma

There is a prevailing message within society that dictates obesity is primarily the responsibility of the individual (Puhl & Huer, 2009). At the forefront of this message is that obesity is simply a result of overeating and lack of exercise and if the individual just alters their behaviour they will alter their condition. If they are unable to do this then they may be stereotyped as lazy, greedy, weak, unsuccessful, lacking self-discipline, little willpower, and are difficult and non-compliant with weight-loss treatments *(*Puhl & Brownell, 2001). In their attempt to support this perspective Sikorski et *al.* (2011) proposed that the stigma and discrimination attributed to the individual with obesity is done so to create "re-integrative shaming" and motivate and encourage the individual to conform to the existing norm of reduced weight and fitness. Puhl and Heuer (2009) reviewed several studies that challenged these assumptions and showed stigma and discrimination to have a negative impact upon the individual. Instead stigma resulted in encouraging poor eating and lack of exercise and ultimately decreasing motivation. Muenning (2008) supports the premise that individuals who are obese suffer psychological stress driven by social stigma associated with being obese. How individuals view themselves when obese and how they are seen by others can negatively impact their self-esteem and how they see their value within society. As an individual who is obese they are then open to experiencing weight-related stigma and discrimination in many areas of their life; social, employment, education and health care (Puhl & Heuer, 2009; Puhl, Moss-Racusin, Schwartz & Brownell, 2008). Resultant psychological distress and/or social isolation may then ensue, all of which can be exacerbated for an individual who is morbidly obese (Lewis, Migliaccio & Donini, 2011). A psychological perspective has been highlighted in this literature review with regard to obesity and

particularly severe obesity which are significant in many areas of the individual's life. Psychological wellbeing needs to be a significant part of treating severe obesity and is considered an important part of a holistic approach to treating the individual. The individual cannot be treated in a dichotomy of mind and body because one impacts the other.

Providing an example of how the individual with obesity views themselves, Rand and Macgregor (1991) reported that individuals who had undergone gastric surgery said that they would rather have been deaf, dyslexic, diabetic or suffer a bad heart disease than return to being morbidly obese. Societal stigma can also create psychological and physical barriers to seeking help and support for weight management. Weight bias and stigma have been demonstrated in health-care professionals' (physicians, nurses, psychologists and medical students) attitudes towards individuals with obesity, believing patients to be lazy, non-compliant and lacking will-power (Puhl & Brownell, 2001). These beliefs whether spoken or unspoken create a divide between health care professions and the patient and could contribute to limiting the desire of the health professional to help the individual. It is also important to recognise that there is also stigma involved from the patient to health care professionals when the professional is overweight or obese; this also creates a divide. The patient was shown to elicit a lack of trust and a reluctance to follow their recommendations on weight loss (Puhl, Gold, Luedicke & DePierre, 2013).

As long as weight stigma remains a socially acceptable form of bias, individuals are going to continue to be negatively affected with continuing physical and

psychological health implications and a reluctance to seek help. Greater knowledge, education and acceptance to understanding individuals with severe obesity will reduce weight stigma.

2.6 Interventions to Overcome Barriers

Having the motivation to change has been an important consideration in the field of weight loss. It is difficult to persuade someone to change their behaviours if they do not want to or find it too difficult to change. Extrinsic motivation is external to the individual and is linked to coercion and control and when it is withdrawn so is the individual's motivation which may identify why weight loss is achievable in the short-term. Identifying a way for the individual to be intrinsically motivated, to have an internal desire and motivation to lose weight, would reflect the natural human propensity to learn and assimilate information themselves with the understanding that they will maintain their motivation themselves (Deci, 1975). This would indicate that intrinsic motivation is required for maintained weight loss to be continued in the long-term. Motivational interviewing (M.I.) is a directive, patient-centred counselling approach which focuses on engaging intrinsic motivation from the patient in order to facilitate weight loss driven by the individual and to help them resolve any ambivalence (Armstrong et *al*, 2011). MI is a psychological intervention that has been shown to be effective in the field of addiction but is as yet to be established in the field of weight maintenance (Armstrong et al, 2011). Nevertheless, the Royal College of Physicians [R.C.P.] (2013) have recommended implementing motivational interviewing as part of weight management intervention because it was found that primary care physicians felt limited in how to treat obesity and identified a lack of effective treatments. D.B.T. and I.P.T. implemented by the N.H.S. are skills taught to

the individual which provide greater awareness to the individual yet require continued practise. If the individual does not have the intrinsic motivation to continue implementing and practicing the skills then they will not receive the benefit. This is where intrinsic motivational interviewing can alter the individual's desire to change for their own benefit, empowering them to perform an activity purely because they wish to (Miller and Rollnick, 1991).

Research by Befort et al. (2006) found physicians felt that patients had low motivation for change. This perceived level of patient's motivation may form part of the stigma found in health-care professionals to treating individuals with obesity. Befort et al. (2006) found that patient's self-reported motivation levels were significantly higher than those predicted by their physicians; indicating a discrepancy between patient and clinician perceived motivated for change. The sigma and lack of belief in the programmes that the patient experiences from the healthcare professional appear to be significant barriers to seeking weight loss interventions.

Sobal and Stunkard (1989) showed that motivation is the key to knowing who will stay on a weight loss programme, lose the most weight and exercise regularly which is essential knowledge in future weight loss interventions. They are individuals who believe that they have the capability to lose weight for themselves and are goal orientated, autonomously motivated individuals who believe intrinsically that they are able to lose and maintain their weight. They believe that they can achieve this goal. The aim is that the individual will then be autonomous and accept that the regulation for change is one's own.

The difference of opinion between physician and patient can be seen as detrimental to a positive relationship. The physician is using motivational interviewing because they are unsure how to treat the individual and believe that they are not motivated. The patient is already feeling motivated but feels the physician does not believe in the efficacy of the intervention.

An alternative approach to M.I. or to work alongside M.I. in obesity management was suggested by Ryan and Deci (2000) who proposed that self-determination theory (S.D.T.). S.D.T. suggests that social constructs support an individual's basic psychological needs for autonomy, competence and relatedness. Autonomy suggests that the individual acts according to their own interests or values in a non-controlling, supportive relationship (Ryan & Deci, 2000). Competence depicts having mastery over your environment and is facilitated by conditions that provide optimal challenges and positive feedback. Relatedness refers to a wish to be connected or a feeling of belonging with others which is facilitated when the individual is treated in a warm and caring way (Ryan et *al*, 2005). Within the present structures in place to help individuals with severe obesity to begin to lose weight and maintain any lost weight, it is questioned whether their basic psychological needs of S.D.T. are being met. If they are not being met it is questioned whether this impacts their motivation to successfully achieve maintained weight loss..

2.7 Conclusion

This literature review examined some of the difficulties that an individual who is severely obese may face in their interaction with food, society and the medical profession. Consideration has been given to the aetiology and theoretical

perspectives regarding obesity management to enable deeper understanding into these interactions. The ability to understand what has influenced the individual in becoming obese, whether it is genetics, physiology, society, psychology, medication, motivation or determination, each can provide insight into the individual.

Consideration has been given to the government guidelines for the treatment of obesity and eating disorders which reveals a lack of belief in the advice that is being provided. It is therefore not surprising that the physicians also appear to have a lack of belief in prescribing them to patients seeking help. In an attempt to help physicians feel more confident in treating individuals with obesity they are being taught motivational interviewing techniques but it appears that patients may already feel motivated. This creates tension between patients and physicians which may add to the stigma identified in both parties. Overall this situation does not instil confidence for the patient to seek professional help and that they will be listened to in an empathic and supportive environment.

This research has questioned the efficacy of the medical model in its approach to treating obesity, particularly with regard to the high attrition rates. There are many contributing factors for this which have been discussed but overall the individual was seen to suffer mental illness and psychological distress in many instances. Poor mental health was the result of one or a combination of many factors; the failure of not achieving weight loss, having mental ill health due to obesity or vice versa, societal stigma, medication and weight gain, repeated dieting and ultimately the vicious cycle of a combination of these. They all impact how the individual feels about themselves, their weight and society and ultimately affect their behaviour.

Although current guidelines recommend psychological therapies for addressing the individual's mental health, there is little clarity around their precise nature of effective psychological treatment. It is also unclear whether there is a generic system across the N.H.S. that implements these treatments. It would appear that more needs to be done to identify what kind of psychological therapy would be beneficial to the individual prior to addressing their weight. Indeed whether weight needs to be addressed at all, or would the H.A.E.S. approach be more beneficial in helping the individual feel autonomous in their decision to change their behaviour.

The literature review has provided theoretical explanations and potential barriers to obtaining maintained weight loss, which can be compared with the findings of this study. In particular this study aimed to look in depth at what facilitated maintained weight loss and how participants had overcome any barriers by using semi-structured interview questions which;

- encouraged the participant to talk freely about their experience of achieving maintained weight loss.
- focused on identifying whether practical external factors facilitated maintained weight loss and/or did they experience any psychological change.
- sought to identify how the participants saw themselves both physically and emotionally when they were severely overweight and as they see themselves now. The aim of which was to focus on possible stigma and level of self-awareness.
- asked participants whether they valued who they were; the aim was to provide insight from the participant's perspective on self-worth.

- Future thinking questions focused on how they would see themselves in two years' to determine the individual's motivation with regard to maintaining their weight loss.

Consideration was given in this study to identify whether the individual began their weight loss with any comorbidities. This was obtained through the use of a participant information questionnaire which clarified, other than weight loss, what other conditions they had to manage; both physical and psychological.

This portfolio study considered participants who successfully achieved maintained weight loss with the aim of providing positive solutions for potential use in broader applications.

Prior to looking at the findings, details of the research methodology and methods will be given to provide a clearer view of the study that was carried out to address the aim of achieving maintained weight loss.

Chapter 3 – Methodology and Methods

3.1 Methodology and Methods

3.1.1 Introduction

This chapter presents the aim of the study. An explanation will be given to the rationale for the choice of a qualitative paradigm and the use of grounded theory methodology. A description of the recruitment process, ethical considerations, data collection and analysis is provided along with an explanation of why the inclusion criterion was strengthened so that the aim of the study could be met more fully.

3.1.2 Aim of the Study

To develop a substantive theory to explain maintained weight loss, to inform recommendations in weight management practice. Objectives to achieve this aim were:

3.1.3 Objectives

1. To obtain insight into how an individual was able to lose weight on a specific weight loss programme or independently.
2. To explore the perceptions and feelings of maintain weight loss from individuals who have achieved and maintained their weight loss.
3. To identify methods to enable other individuals to achieve successful maintained weight loss.
4. To provide an understanding of what facilitates maintained weight loss.

3.2 Methodology

3.2.1 Philosophical Perspective

High quality research depends on a sound philosophical perspective that dictates the paradigm choice which contributes to the methodological underpinning of a study (Hennick, Hutter & Bailey, 2011). The positivist paradigm seeks to discover causal explanations and make predictions about the world whilst ensuring scientific rigour objectivity, validity and generalisability. The researcher remains throughout the research as an unbiased and value-free observer (Corbin & Strauss, 2008). The positivist paradigm was felt to be limiting in achieving the aim of this research; to obtain deeper knowledge through intuitiveness and interpreting meanings directly from the participants. This relates more specifically to an ideographic perspective in gaining insight into the social constructs and meanings that participants place on their experiences.

The theoretical epistemology this study took was subjectivism with an interpretive paradigm that has underlying assumptions for qualitative research, again reflecting the study's aim for understanding each individual's experience. The interpretive paradigm assumes that an individual within the social world can only be understood by identifying how they give meaning to behaviour and events in their lives. Qualitative research allows the researcher to gain insight into how the individual constructs reality through language and its meanings, providing a forum for holistic understanding of the individual's experience (Hennink et al, 2011).

The interpretive paradigm recognises that reality is socially constructed from people's experiences within historical, cultural, social and personal contexts that are felt important to acknowledge and explore. Everybody brings their own unique perspective and experiences to achieving and maintaining weight loss, there are therefore multiple interpretations from how individuals construct their own reality. Some interpretations may be recognised across participants' experiences thus providing for robust potentially transferable data (Silverman, 2011). The value of qualitative research allows the researcher to be in a position of inclusion with the participant as well as the research, rather than as an objective researcher. Consideration was given to qualitative methodological approaches in particular interpretative phenomenology (I.P.A.) and grounded theory (G.T.). Both allow the data and consequent themes/theory to be co-constructed with the researcher as a result of their interactions. This therefore enables active participation in understanding the participants' concepts of reality. Phenomenological research provides rich and full meanings of what it means to be a person in their particular world and as a result is able to obtain in-depth knowledge in often unexplored areas (Smith, Flowers & Larkin, 2009). Whilst this methodology is valuable in its approach, the focus of this research was to obtain a substantive theory to explain maintained weight loss with the intention of contributing towards future weight loss interventions. Therefore the methodology identified for this study was Charmaz's (2006) grounded theory using a social constructionist's perspective. The methodological framework for Charmaz's grounded theory assumes that people construct themselves, society and reality through interaction (Charmaz, 2006).

3.2.2 Grounded Theory

Grounded theory is a specific methodology originally developed by Glaser and Strauss (1967) with the aim of producing a substantive theory that explains a particular social interaction/situation from collected data. Glaser and Strauss' (1967) grounded theory provided a systematic qualitative analysis, using logic and a resultant theory using narrow empiricism (Charmaz, 2006). Strauss and Corbin's (1998) approach to data analysis is prescriptive and systematic whilst placing the researcher at a distance to the interaction and involvement with participants, stating that the theory was emergent from the data (Cho & Lee, 2014).

It was felt this research required a methodology which stayed close to the data to enable the researcher to actively co-construct an interpretive portrayal of maintained weight loss; therefore Charmaz's (2006) social constructionist's grounded theory approach was used. Charmaz (2006) constructs theories from the data itself and her guidelines offer general principles and heuristic devices. This study gained this insight through semi-structured interviews and grounded theory analysis to provide an interpretive portrayal of maintained weight loss.

3.2.3 Ethical Considerations

Ethical approval was obtained from the Faculty of Education, Health and Wellbeing Ethics Sub-Committee Board of Wolverhampton University (Appendix A) and a favourable ethical opinion was granted from an N.H.S. Regional Ethics Committee via the Integrated Research Application System (I.R.A.S.) (Appendix B). This study presented minimal risk to participants which enabled ethical approval to be sought from N.H.S. Proportionate Review (P.R.). P.R. provided a more succinct process in

obtaining N.H.S. ethical approval. Local N.H.S. Research and Development and Site Specific Assessment approval were sought and approved (Confidential Appendix).

To ensure further rigorous ethical standards I adhered at all times throughout the study to the British Psychological Society [B.P.S.] (2008) which promotes psychological excellence and ethical practice and also to the Health and Care Professions Council [H.C.P.C.] (2012) standards of conduct, performance and ethics which is an independent regulator of health and care professionals ensuring high standards are met to support and protect the clients.

All identifying information relating to participants was kept securely by myself on a password protected computer in a locked office. Consent forms (Appendix E) were kept in a locked cabinet within the locked office. All data was anonymised by removing any identifiable information and replacing it with pseudonyms (Confidential Appendix).

3.2.3.1 Informed consent

Any questions the participants had about the study were answered in as much detail as possible prior to asking the participant to sign the consent form immediately before the start of the interview.

3.2.3.2 Potential for Harm to Participant

Participants were advised in the information sheet (Appendix D) and debrief sheet (Appendix H) that there were no obvious risks to taking part in this research. If any

individual became upset in the interview I had planned to stop the interview and ask the participant if they wished to continue. Any decision would be respected. The first participant did become upset in the interview but instructed me to proceed with another question. I thanked her for sharing her information and continued as instructed, after feeling certain that the participant wanted to continue.

3.2.3.3 Lone Working Policy

Four of the interviews were carried out at the homes of the participants. I then followed the guidance for lone workers provided by the Centre for Health and Social Care at the University of Wolverhampton (Appendix K).

3.2.3.4 Right to withdraw

Each participant was informed of their right to withdraw from the research at any stage and my contact details and those of both my supervisors were provided on the information sheet and consent form. These two forms were forwarded by email to the participants prior to the interview to read in their own time. Their right to withdraw was also repeated verbally to each participant immediately prior to the interview.

3.3 Method

3.3.1 Research design

This study used Charmaz's (2008) grounded theory methodology because it allowed for co-construction of a substantive theory to explain maintained weight loss.

3.3.2 Sampling and Recruitment Strategy

3.3.3 Participants

A total of seven adult participants took part in this study; three men and four women aged between 31- 61 years of age (mean = 49). The participants were required to have had a B.M.I. of 35 or above at the start of their weight loss and to have reached their goal weight and maintained that weight for at least one year.

It was felt important that the research tried to obtain a number of male participants who had achieved maintained weight loss primarily due to the scarcity of research in this area as well as facilitating comparisons with female participants.

Two of the participants were recruited through a N.H.S. weight management programme; two by word of mouth; with the remaining three recruited through Overeaters Anonymous (O.A.). O.A. is Fellowship of people who follow and run a programme of recovery specifically for individuals with eating disorders. O.A. is based on a 12 Step recovery process of Alcoholics Anonymous (Overeaters Anonymous, 2013). The participants were purposively sampled based to the knowledge of specific groups/weight loss programmes which used interventions for severely obese individuals. Snowball sampling was used to recruit the last two participants; this was due to the difficulty of obtaining any other participants despite extensive advertising. Purposive sampling allowed this very specific and difficult to reach participant inclusion criteria to be met.

Table 3.3.3 *Inclusion criteria*

Initial Recruitment criteria	Amended Recruitment Criteria
➢ Participants must be 18 years or over. ➢ Participants must be able to give informed consent. ➢ Participants must have had a BMI of 35 or above at the start of their weight loss. ➢ Participants must have maintained an intentional weight loss of at least 10% of their original weight for at least one year.	➢ Participants must be 18 years or over. ➢ Participants must be able to give informed consent. ➢ Participants must have had a BMI of 35 or above at the start of their weight loss. ➢ Participants must have reached their goal weight and maintained that weight for at least one year.

Following the completion of four semi-structured interviews it was felt that the 10% maintained weight loss did not demonstrate stable maintained weight loss particularly with individuals who were severely obese. In line with the purposive sampling strategy employed when undertaking grounded theory, it was of interest to conduct interviews with individuals who were stable in achieving their maintained goal weight. Therefore ethical approval was sought and obtained to amend the inclusion criteria (Confidential Appendix).

3.3.3.1 N.H.S. Participant Recruitment

Initial participant recruitment occurred through a N.H.S. weight loss programme. A participant study pack was given to a N.H.S. Service and they added their own letter to the pack, the aim of which was to introduce and endorse this study to participants who had left their weight loss programme. The pack was then posted out to 27 potential participants who had been on their weight loss programme. The participant pack contained;

a) A letter of introduction from me, requesting participants to take part in the study. My contact email address and mobile telephone number were included in the letter (Appendix C).
b) An information sheet explaining the aims of the study and exactly what would be expected of the participant should they decide to take part in the study (Appendix D).

The participants were asked to contact me via email or mobile telephone number if they were interested in taking part in the study. After making contact a mutually convenient date and venue, for the interview was arranged, by email or telephone. The participant was forwarded the consent form (Appendix E) to read prior to the interview.

Four other N.H.S. weight management programmes were contacted but were either unable to commit or only provided treatment for anorexia nervosa and bulimia nervosa and therefore unable to help.

3.3.3.2 Non-N.H.S. Participant Recruitment

Following ethical approval an advertisement with the aim of recruiting further participants was taken by myself and my supervisor to local fitness centres and emailed to numerous health and fitness centres, weight loss groups, and running/cycling clubs throughout the U.K. An advertisement was placed in a local newspaper with the potential of reaching 45,000 people. No participants were received from the above sources. The search for participants extended to advertising

on the internet sites of official weight management charities. One participant responded from this advertising but did not reach the full inclusion criteria.

The advertisement was emailed to O.A. head office and they emailed it out to their Groups across the U.K. Three participants from O.A. responded and were included in the study. One participant did not reach all the inclusion criteria but it was decided to include her because she had maintained a healthy weight for 18 years from commencing weight loss at a BMI of 31.6. The second O.A. participant emailed other O.A. members to find other potential participants; a third O.A. participant was obtained this way. The remaining participants in this study were recruited by me from information given by word of mouth. Potential participants were asked to contact me by email if they were interested in joining the study. When the participants contacted me (via email) they were sent the recruitment pack by email (Version 2 of the introduction letter, information sheet and consent form which had the mention of an N.H.S. weight management programme removed) and a mutually convenient date/time/place, Skype or telephone call was arranged by email for the interview.

3.3.4 Data Collection

Qualitative, semi-structured interviews were carried out with each participant. Interviews were conducted between 7th June 2014 and 23rd March 2015 and lasted between 43 -93 minutes. Four of the interviews were recorded in the participants' homes for which I adhered to the lone-worker's policy (Appendix K). A further interview was carried out by telephone and two were by Skype (non-video). Prior to recording the interview the participant was asked if they had read the information

sheet and consent form that had been forwarded to them by email. The participants were informed that any identifying information would be removed from the interviews and anonymised. The consent form was signed by the participant prior to interview. The participants who were interviewed over Skype and telephone were recorded giving verbal consent prior to interview. All these participants were asked whether they wanted a stamped addressed envelope to return the signed consent form. All declined this offer. Two consent forms were posted back to the university address and one participant scanned it and emailed it back to me. They were informed that the interview was expected to last between 30 – 60 minutes.

An interview schedule (Appendix I) was used as a guide for the interview to ensure the objectives of the study were met. A data collection form (Appendix F) was completed by the participant (or myself if the interview was via Skype or telephone) prior to interview. This form asked for limited demographic and medical information, for example comorbidities at the time of starting weight loss (for collated information see Appendix G). This data enabled me to calculate the participant's B.M.I. both at the start of weight loss and at the time of interview and identify any medical conditions they had to manage throughout their weight loss.

The interview was recorded on a hand-held voice recorder in addition to a voice recorder app on a mobile telephone as a back-up; this was password protected and was transferred to a password protected laptop to ensure confidentiality immediately after the interview ended. Field notes were briefly written during the interview where necessary, but active listening was felt to be important to aid the interview process. At the end for the interviews the participant was thanked for taking part in the

research and a debrief sheet (Appendix H) was given to them detailing the aims of the study. The sheet also listed local and national charities related to eating disorders and listening services should taking part in the research have raised any issues or concerns.

3.3.5 Data analysis

Each interview was transcribed verbatim as soon after the interview as feasible and the data was anonymised. I listened to each interview a minimum of three times to ensure an accurate transcription was obtained and to become immersed in the data. I documented pre and post interview reflective (field) notes to provide context for the interview and to record impressions and interactions of the participant and myself (Confidential Appendix).

Analysis of interviews began immediately following each transcription. Analysis involved coding; primarily with gerund initial coding which involved line by line coding to ensure that the process from the data was obtained and then the initial codes were elevated to form focused codes. A detailed explanation of how the initial and focused codes were analysed to form categories can be seen in Appendices L, M and N. A condensed example can be seen in Table 3.3.5.

Table 3.3.5 *Example of a section of interview dialogue with initial and focused coding*

Interview Dialogue – Claire, Line 108 **Client dialogue in red/interviewer in black**	**Gerund Initial Coding**	**Focused Coding**
"It was great. I'm not knocking it at all because she was fabulous and she was very good and it was very helpful (mmm). It helped me understand a lot about myself, why I overate and all sorts, I've learnt a lot about me but on a daily basis I still was unable to stop it (right) it wasn't really enough".	Appreciating therapy Establishing quality of help Gaining understanding Gaining awareness Lacking control	Gaining Awareness Lacking Control

At the same time of completing analysis, memoing of my thought processes and interpretations from the data were recorded to establish an audit trail (see Appendix M for a sample of memoing). The codes allowed for grouping into categories following constant comparison with the data/memoing/focused coding and decisions made by myself. Elliott and Lazenbatt, (2005) identified that the use of memoing and constant comparative analysis ensured that categories which have been developed can be identified as grounded in the data. Interview questions were amended following the interviews, as and when it was felt appropriate, as a result of coding to ensure that the core research objectives were being adhered to (Appendix I). Recruitment was ceased primarily due to the difficulty in obtaining participants within the revised inclusion criteria and time restrictions on the research deadline. It was felt that saturation of the data was achieved in terms of repeated constructs being observed (identified in Appendix J) but it is unknown whether the saturation of theoretical concepts had been achieved.

3.4 Trustworthiness

Ensuring rigour of qualitative research is of paramount importance when conducting a research study. For this study rigour was achieved through the use of trustworthiness which was adhered to in the following way;

Guba (1981) proposed using four components;

- Credibility — asks how congruent the findings are with reality.
- Dependability — showing that the findings are consistent and could be repeated.
- Confirmability — a degree of neutrality or the extent to which the findings of a study are shaped by the participants, not researcher bias, motivation, or interest.
- Transferability — showing that the findings have applicability in other contexts.

This research has used the following to show trustworthiness in this study;

3.4.1 Credibility

- *Well established qualitative data analysis*; this research has used grounded theory which adheres to a structural analysis with clear recordings of interpretations.
- *Researcher's reflective commentary*; subjective meanings and perceptions have been carefully detailed using memos and reflective writing consistent with grounded theory (Krefting, 1990). First impressions upon meeting each

participant and field notes following each interview have been documented by me/interviewer to allow openness and insight to my perspective.

- *Purposive sampling* was used in addition to snowball sampling. The latter was due to the difficulty in finding participants to meet the revised inclusion criteria.
- *No research funding* has been applied for and is therefore not restricted by any other criteria.
- *Triangulation*; Individual and site triangulation was obtained by using different participants from different sites.
- *Encourage honesty in informants when contributing*; Participants were to the best of my ability put at their ease prior to the interview with short dialogue and they were given scope and support to tell their story.
- I have not worked in the area of research being undertaken and therefore had no pre-conceived knowledge and expectations from the participants.
- *Frequent debriefing sessions*; the research team confirm or identify alternative emergent codes/categories from the data (Barbour, 2001). *Peer examination* of the research project; this research has been presented at the:-
  1) British Psychological Society Counselling Psychology Conference 2014, via poster presentation (3rd prize).
  2) To the counselling psychology peer groups and staff members at the University of Wolverhampton via power point presentation.
  3) To an Eating Behaviour Research Interest Group Seminar 2015 to staff students and external members in the University of Wolverhampton via power point presentation.
  4) Peers from the course met to review the analysis.

- *Member checking*; checking for clarity of data information during each interview was obtained.

3.4.2 Dependability

- In-depth methodological description has been provided to inform future researchers of the method and procedure for this study.
- Reflective appraisal of the study has been included to provide insight and openness from my perspective in this study.

3.4.3 Confirmability

By detailing any decisions made and methods used through the use of on-going reflective commentary this provides readers with an understanding of the context in which the study was carried out.

- Triangulation; regular reviews of the research and contributions from the research team were obtained in addition to peer reviews.
- Recognition of shortcomings in the study's methods and the impact these may have are detailed in Chapter 6 - Critical Appraisal.
- Detailed methodological description.

3.4.4 Transferability

The extent to which the findings of a qualitative study can be applied to another may be difficult to replicate (Erlandson, Harris, Skipper & Allen, 1993). In qualitative research each study is unique within its own context; this does not mean that they cannot also be used to contribute towards a baseline understanding for other work to be compared against. To facilitate this, explicit contextual details are required for

future studies and these have been included in the research method and in the reflective writing (Confidential Appendix). For this study Shenton's (2004) recommended background data are provided to establish contextual requirements;

- Number of organisations taking part in the study and where they are based; detailed in the N.H.S. ethical application form (I.R.A.S. application in Confidential file)
- Any restrictions in the type of people who contributed to the data; *Individuals had to fit the inclusion criteria.*
- The number of participants involved in the fieldwork; *one researcher carried out all the interviews which were in participant's homes or via Skype or telephone.*
- The data collection methods that were employed; *semi-structured interviews were carried out in all the interviews.*

3.5 Summary

Clear details of the methodology and an explanation for the reasons for choosing Charmaz's grounded theory for this study have been provided. The method has provided insight into the participant characteristics and recruitment process, data collection and analysis.

The findings from the data analysis will now be presented which provide a storyline to maintained weight loss.

Chapter 4 – Findings

4.1 Introduction

Data from the interviews were analysed using grounded theory to obtain a substantive theory of maintained weight loss. The first two objectives of this study had been achieved by obtaining insight directly from the individuals who met the study's inclusion criteria. By analysing each interview consecutively and then using constant comparison of the data, seven categories were constructed; 'Normalizing', 'Controlling', 'Isolating', 'Seeking', 'Gaining', 'Analysing' and 'Choosing'. The seven categories integrated to form a core eighth category of 'Emergent Self'. The categories revealed a process of growing self-awareness and formed a storyline of a substantive theory of maintained weight loss. Each category and their subthemes will be examined independently to explain why certain individuals are able to achieve maintained weight loss whilst identifying methods to enable other individuals to achieve this aim. As a means of providing insight into the individual's construct of their experiences to maintained weight loss, excerpts of the participant interviews will be used to illustrate their perspectives.

All identifying information has been removed to ensure confidentiality and the members from O.A. – Claire, Linda and Charles (pseudonym names) wanted to highlight that it is their own personal experiences and views that they are sharing; they are not representing the view of O.A.

4.2 Findings

4.2.1 Participants

Table 4.2.1 includes details of the seven participants, their means of weight loss, what inclusion criteria they met and whether they were maintaining their weight at

the time of the study. By providing these details below allows for a full and clear perspective in understanding the results of this study. The participant's full weight loss details can be found in Appendix F.

Table 4.2.1 *Present weight status of participants*

Participant	**Weight loss Facilitator**	**Maintained Weight Loss – at 10% or Goal Weight for at least one year**	**Present Status**
Jane	Finished N.H.S. Weight Management Programme	10% of original weight	Maintaining 10% loss but fluctuating (alternating between increasing/decreasing in weight)
David	Finished N.H.S. Weight Management Programme	10% of original weight	Maintaining 10% loss but fluctuating
Sarah	Overeaters Anonymous	10% of original weight	Maintaining 10% loss and still losing weight
Ian	Independent	10% of original weight	Fluctuating
Claire	Overeaters Anonymous	Goal Weight	Maintaining
Linda	Overeaters Anonymous	Goal Weight	Maintaining
Charles	Overeaters Anonymous	Goal Weight	Maintaining

The seven categories and the core category 'Emergent Self' are presented below in Figure 4.2.2 to show the storyline of maintained weight loss. Each category will be discussed to show the process to facilitating maintained weight loss.

Theory of Emergent Self showing the storyline and category integration; 'becoming prominent the conscious knowledge of one's own character, feelings, motives and desires'

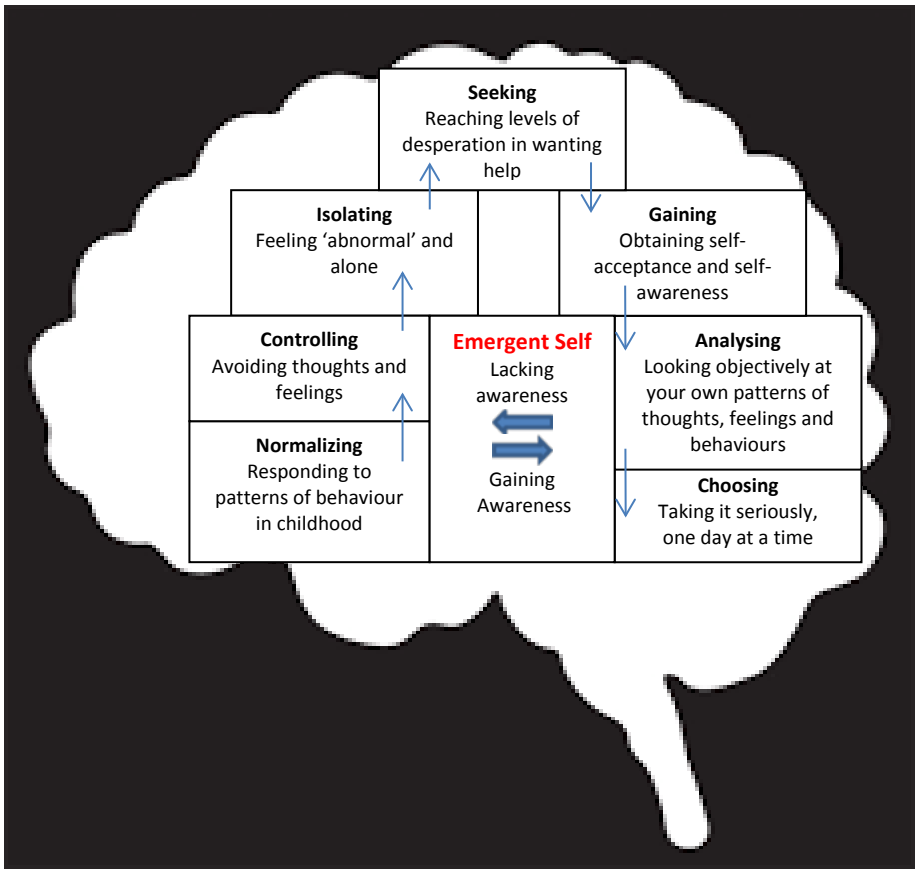

Figure 4.2.2 Storyline of Weight Maintenance

4.2.2 Storyline of Maintained Weight Loss

This storyline of maintained weight loss revealed the process that the individual experiences; moving from lacking self-awareness in childhood through to gaining self-awareness in adulthood. The 'Emergent Self' showed the individual becoming consciously aware of their own character, feelings, motives and desires. This awareness or introspection that they gained enabled them to recognise their own desires, feelings, and habits which then provided awareness and understanding of their relationship with food. The aim would be to understand oneself better and to accept yourself; this then enables the individual to proactively manage their thoughts, emotions and behaviours to then act consciously rather than passively in this case around food (Goleman, 1996). This awareness can place the individual in a position of being able to choose what their future relationship with food will be rather than being on automatic pilot with little awareness of themselves or their relationship with food.

The core category of emergent self was an analytical interpretation from the seven interviews which formed this grounded theory of maintained weight loss. There were three participants who achieved maintained weight loss and it is felt important to note that whilst these O.A. members made it clear that they were providing their subjective perspectives on their experiences, they had all completed the O.A. 12 Step Programme. The 12 Step programme has a very structured approach with specific terminology which may have influenced the participants' perspectives. Nevertheless this research is looking at the barriers and facilitators to maintained weight loss therefore if aspects of the O.A. programme are identified as contributing to either of these this is considered beneficial to the research. The research aim is

to identify a grounded theory to maintained weight loss which was derived from all the data therefore although the O.A. members had achieved maintained weight loss the other participants had lost 10% of their original weight. They are able to present what facilitated their weight loss and the barriers to continued weight loss/maintenance. It is therefore imperative to include all the interviews in the analysis and findings which will contribute towards the grounded theory. The storyline focuses on the underlying process that was occurring for the individuals as they achieved maintained weight loss. It identified that for these individuals the foundation of their behavioural pattern of overeating began in childhood with limited awareness of their relationship with food. As adults they appeared to try to avoid their emotions, initially using food and this created a veil of secrecy and shame so much so that reaching out to others for help became almost impossible. The participants felt a sense of being abnormal compared to the rest of society along with a feeling that overeating is not taken seriously enough. It is only when they reached a level of desperation that some individuals seek help but this is found to be limited in success. The individuals in the study were facilitated in maintained weight loss through gaining self-awareness and self-acceptance which then gave them the opportunity to maintain their weight loss, a day at a time.

4.3 Normalising: Responding to Patterns of Behaviour in Childhood

Six of the participants identified patterns of behaviour first experienced in childhood, where food was the main focus. Examples of behavioural associations included; being given large portions as a child; one of the reasons this occurred was because the parents themselves did not have sufficient food when they were growing up and they then overcompensated with their own children. Other examples included

having to clear their plate of all food, having second helpings, a feeling of never being full and therefore not learning satiety. Two of the participants said that their parents and siblings were all obese and this normalised their view of weight and health. They identified early problematic eating behaviours around types of food;

> *"…if ever getting money and things I would always buy sweets and things like that with it and so sugar was quite an early problem I suppose"* (Linda, Line 59)

With regard to emotional associations; one participant was living in an abusive family and secretly being given sweet food to make everything seem better, she continued using food for comfort even when she was placed into care. For others similar childhood associations with food and emotions were formed;

> "*Food was very important for our family…like the currency; you know it was like love on a plate really*." (Claire, Line 122)

Each of these early associations with food, both positive and negative, presented a conditioned response to food which can be carried into adulthood, often without awareness of the emotional or behavioural response.

A good example of emotional and behavioural response carried forward into adulthood was identified in one participant who had never experienced three healthy meals a day. Their behavioural response to food was to eat whenever it was presented because they had learnt as a child that they did not know when their next meal was going to be and often went hungry. In this instance weight was managed

with the practical implementation of three regular meals a day. It was possible to establish an eating pattern and then gradually move to healthier foods. This involved eating as much as they wanted within the three meals until they were reassured that the food was there for them. This focus was initially not on weight loss or weight but establishing a healthy eating pattern.

From a clinical perspective, an individual's lack of awareness for their own eating behaviours may not be apparent whilst they are able to counterbalance physical expenditure with calorie consumption. Their overeating becomes obvious when they gain a sedentary life-style and their weight increases. Even though individuals may become desperate to change their eating patterns this was found extremely difficult to accomplish. This is because they had formed such a strong attachment to certain foods or the feeling they get from being so full;

> *"I didn't want to eat but I was doing it almost against my will is how I would describe it ….my head was telling me it was wrong but I couldn't stop"* (Sarah, Line 323),

The strength of their childhood attachment to food appeared to contribute to their present day eating behaviour. This long-established eating pattern would be difficult to change to one of eating in response to hunger and not emotions.

4.4 Controlling – Avoiding Thoughts and Feelings

Throughout the first two interviews Jane and David showed limited acknowledgement of their feelings. David was unable to reflect on how he felt and

could not say whether he valued himself. Jane focused on intellectualising things and providing facts. This lack of emotional content in their interviews became apparent following the third interview with Sarah who was very open and self-aware.

David's way of coping with bullying throughout his time at school was to "*just let it go straight over my head*" (Line 453) even though he acknowledged that it had hurt him. At the time he said "*I thought it was part of who I was…. I just let it go really*" (Line 460). This may have indicated an element of internalising the negative impact from bullying. Jane dismissed her emotions when she became upset and wanted to return to her original demeanour saying; "*just, just emotion ….I've done this all my life so don't worry about it*" (Line 833). This approach to managing emotions by using avoidance was identified by Charles prior to his weight maintenance. He used food so that he did not need to think or feel difficult emotions;

> "*I've stuffed kinda feelings down you know*" (Charles, Line 454)
> *"I used to find that if things are blocking my head if I got up during the night for the toilet or anything like that I'd visit the fridge*" (Charles, Line 631)

Another means to avoid emotions was noted with Jane and David who focused on spending time logging their weight, exercise and food into apps and computers and measuring portion sizes. These participants created an external focus; time and energy spent struggling without losing and maintaining their weight. Working therapeutically would therefore need to be carefully managed to identify where emotional regulation was still taking a maladaptive form.

The participants who have now achieved maintained weight loss were able to recognise this past behaviour;

> "*I mean I did an awful lot of overeating…I also did an awful lot of thinking about it too…or planning how I was going to lose the weight, I spent a lot of mental energy on all of that so the fact that I don't have to do that anymore…..I live differently.*" (Claire, Line 504)

The participants who had maintained their weight loss did so by spending their energy on being aware of what was happening for them, what they were thinking and feeling and they did this by using self-reflection. They also spent a lot of time giving and receiving emotional and practical support. The participants were learning to look internally at themselves, how they felt as well as well as externally at others.

In addition to using food to avoid difficult emotions, it was also used to celebrate positive emotions;

> "*I ... don't really have that urge to overeat when faced with any sort of difficulty or even a nice thing you know, I used to overeat to celebrate*." (Claire, Line 428)

It appeared that both negative and positive thoughts and feelings are managed with food. The participants who maintained their weight loss learnt how to manage difficult feelings and face them rather than avoid them. It is questioned whether the participants who managed their emotions with food had not learnt emotional

regulation in childhood due to experiencing an environment that may have been lacking in stability, security and/or love.

With regard to clinical implications; the participants have demonstrated complete opposites in their approach to maintained weight loss. The participants who were not maintaining their weight were focusing externally in an attempt to try to avoid looking internally at themselves. Whilst successful maintained weight loss has been achieved by looking internally at their thoughts and feelings and learning how to manage them.

4.4.1 Emotional Attachment

It has been shown that there was an emotional attachment to food formed in childhood. The strength and type of that attachment can be seen in how participants talked about food and how they used food. Food was not just seen as nutrition for the body, there was a lot of meaning placed upon food particularly to how it made them feel, even extending to having the ability to make them feel wanted;

> "*It made me feel as if I was, as if I don't know it made me feel comfortable, it made me feel kinda warm, made me feel wanted sort of stuff." (*Charles, Line 413)

> "*I I knew that whatever happened to me if I could get something sweet to eat I would be OK…..calmed me down…*" (Claire, Line 129)

Not only could certain emotions be induced by the use of food, but the intensity of emotions may also be managed in this way. For example, the difficulty of managing the intensity of their emotions could be seen by Sarah who managed to abstain from alcohol and is becoming a healthy weight. She managed her emotions not through food but through writing them down with the support from O.A. She said how she responded when she had some upsetting news and she went into a 'dark hole';

> "*When I heard it I just absolutely went in a corner and that's not me. I managed it without drink, without stuffing my face because I looked at the truth and the facts. Cause I don't want to see the.. when I hear something like that….I don't know how to look at them because I'm hurt*." (Sarah, Line 733)

Sarah appeared to react purely with emotions which clouded her judgement and stopped her from seeing the full picture of the event. She responded instinctively and very emotionally to hearing difficult events; which is a natural response, the difference being that she then seemed stuck in them unable to get herself out. With support from an O.A. sponsor; this is someone who had been through the 12 step programme, Sarah wrote her feelings down and her sponsor provided her with an objective perspective to the situation. The next process would be to begin to regulate her emotions independently and be able to cope with the feeling her emotions brought and to stand back and be objective to the situation she is in without the necessity for an objective perspective. It is unclear whether O.A. members become fully independent from sponsors, it may be a very gradual process and happen over time and then consider sponsors in the same way a supportive family may be utilised. This provides clinical implications with regard to achieving

emotional regulation for participants in a supportive environment and learning how to manage their emotions objectively.

Participants appeared to constantly struggle to balance their lives and initially food made them feel better and brought a sense of control. The use of food to regulate the individual's emotional state was evident. It has been possible to see how they used food, whether they used it as Claire did to celebrate a positive feeling or to seek food out to help calm her negative feelings or Charles who avoided negative thoughts and feelings. It was questioned whether using food as an emotional regulator was also connected to the kind of attachment they received as a child; this was difficult to establish in this study. It appears that the reassurance that one would have received from a mother or main caregiver was substituted or aided by food. The clinical implication here could be to consider self-soothing techniques as an intervention and to ensure the individual was able to process and manage their emotions independently.

4.4.2 Avoiding Self

Thoughts, feelings and the resultant behaviours are all closely connected and the majority of the participants were able to identify significant stressful events in their lives past and present. The distress they felt from these events they managed with food to help them feel better. Additionally they were able to identify how some of the things they had done in their lives had impacted how they see themselves now; as good or bad people. Two of the participants were able to share how they wanted to avoid being with themselves and in order to do this they ate excessively.

> "*I'd have to tell people I did na have their money and um um that fear then would then take me down to the shop you know for takeaways and junk food and stuff like that."* (Charles, L178)

> *"I just loved eating and loved food and then found alcohol, I loved alcohol and I couldn't get enough of that. Do you know… it was always like something to make me feel different about myself….a sense of just not being able to sit with yourself and so you have to do something to try and not sit with yourself."* (Linda, Line 534)

From a clinical perspective in depth psychological therapy would address past and present life events in addition to working towards improving the individual's self-esteem. The aim of psychological therapy would be to encourage intrinsic motivation for change, increase self-esteem and change core beliefs without which an individual may not feel they are worthy.

Charles developed a pattern of having to complete all the tasks in his tray at work otherwise he would have felt as if he had failed. This approach to trying to make himself feel better using external means would only work as long as he could sustain completing the tasks. It is a fragile way to feel better. If he was able to change the way he feels inside he will have more stable self-esteem. Another way of avoiding themselves was identified with Charles and Linda who said that they would spend a lot of time worrying about other peoples' problems trying to fix them. Linda felt that this was another way of getting away from herself and focusing externally, which was something that was identified with Jane and David.

Both Linda and Charles have found a way of accepting themselves and feeling more relaxed with who they are which has been critical in their weight maintenance.

For those who have not found acceptance the escape that food can provide occurs when the quantity of food consumed created a physical and psychological response in the individual, producing what participants called ‘a high’.

> “*The kinda high and the coma that you go into once you’ve had a big binge….you know you can’t hold a proper conversation, you can’t get up off the couch, you know it’s that bad*” (Linda, Line 766)

> “*I was taking seven or eight thousand calories in a day”* (Charles, Line 375)

This begins to highlight just how dangerous this level of overeating can become both to the individual and society, for example overeating whilst driving. One participant would eat a main meal whilst driving; therefore the physical act of eating and the resultant high that large amounts of food provide indicate the danger. The participants felt that society does not presently appear to acknowledge the seriousness of this condition which has implications for the patient; practitioner relationship creating a barrier to treatment.

4.4.3 Control and Powerlessness

The sense of control the individual initially obtained by using food to manage their emotions became a feeling of being out of control with food over a period of time. Four of the participants, three of whom were maintaining their weight, were able to

identify that prior to losing weight they had lost their ability to control themselves around food.

In these excerpts Claire showed how she felt about herself before and after maintained weight loss;

> "*There was something really radically wrong with me that made me go into the binges and the eating, I couldn't stop."* (Claire, Line 62)

> *"…there is all the stuff lined up there cakes, chocolates …….. it would shout at me this stuff, if I had that food in the house it would scream at me you see from three doors down, you see but it doesn't call to me at all…"* (Claire, Line 508)

Food became their focus for life so much so that some of the participants were willing to obtain food through deception and fighting. This reveals the depth of their attachment to food. This demonstration of extreme emotion was portrayed in their lives through their all or nothing approach with food and dieting and reveals the imbalance that they experience.

> *"I only knew really how to do the diet or overeat, I never knew how to eat steadily and moderately so that my weight stayed steady and moderate…I don't have any recollection of it ever being that way."* (Claire, Line 38)

It was identified that all participants prior to maintenance highlighted a lack of control in their lives and a sense of powerlessness around food. Jane, David and Ian who were all fluctuating in weight did not mention that they felt powerless around food. The individuals who were maintaining their weight loss all acknowledged this lack of control and powerlessness in O.A. at the start of weight maintenance. This may be of clinical significance; as this might be the first step towards acknowledging openly to themselves and others that they need help. Admitting to being powerless over food was particularly difficult for Charles. He identified denying that he was powerless as a reflection of wanting to maintain a macho image as well as feeling that society may judge him negatively.

> "*You have to be at your gutter level. You have to admit to yourself that you're totally powerless um and it is I think it is especially hard for a man to say he is powerless, especially with food because loads of people can be powerless over alcohol and different drugs but to tell someone the shame of actually telling somebody that you are powerless over food.*" (Charles, Line 481)

Charles entered the group only because he took a relative and he acknowledged that there were very few men in the group when he joined which was a deterrent for him. More men are attending now possibly because he has managed to speak out and lead the way for other men. Encouraging men to attend a group would be an important consideration in planning weight management interventions. An all-male or a group of equal sexes may encourage more males to seek help.

4.4.4 Negative Cycles

Recurrent negative cycles appeared to be a theme running through the interviews with participants unable to break their cycle themselves. Linda's obesity originated from having several significant life events, becoming depressed, managing emotions through food, becoming very overweight, increasing depression etc. Unfortunately, Linda was not able to identify a significant link between her depression and overeating nor did the clinicians she sought help from and so her cycle continued until she felt suicidal. Looking back she remembers that;

> "*When I was well mentally my weight would go down because I wouldn't need to comfort eat so much*." (Linda, Line 21)

Linda did not break the negative cycle until she attended the O.A. 12 step programme which showed her how to be self-aware which in turn helped her become aware of her relationship with food. She became more accepting of herself. Claire also had depression whilst losing weight and maintaining, she was the only other participant who reported having had mental illness.

Another area identified for repeating negative cycles resulted from four of the participants attending commercial slimming clubs. Again the sense of having to keep a control over their food intake was emphasized allowing treats as long as they were monitored. Participants reported being able to lose weight in the short term but the weight returned after leaving the programme. They would then attend the club again, heavier than they had been the first time they attended; this was reported as demoralising and embarrassing with a feeling of great shame which again erodes the individual's self-esteem. With regard to clinical practice this is of utmost importance.

There seems to be a resistance to emphasize abstinence, possibly due to the lack of seriousness placed upon this condition or of depriving the individual. What are seen as treats are detrimental to the individual's health; food treats should be seen in the same way as you treat an alcoholic. A participant stated this message clearly by saying that an alcoholic would not be offered the occasional whisky.

> "*Every time I lost weight I would then put that weight back on and I always put on more, um so in some ways I sort of dieted myself up to twenty two and a half stone"* (Linda, Line 112)

The three participants who are now maintaining their goal weight identified that because the focus of the commercial slimming clubs was primarily on food and weight loss they were unsuccessful in helping individuals achieve maintained weight loss. They look back in disbelief that there was no psychological perspective to the programmes which was a critical aspect to their recovery and maintenance. As participants reflected back on their attendance at the slimming clubs they appeared sceptical of the slimming club's approach; recognising that addressing why people were overeating was not considered. This therefore sustains a negative cycle of weight loss and weight gain, which eventually is very demoralising and 'soul destroying' for the individual.

> *"When I look back now it was crazy, there was no psychological feeling component to why we're we're all fat, it was just about well if you just do this with your chicken satay or whatever it was, it was just crazy superficial talk really whereas in O.A. it is very real, very honest."* (Claire, Line 195)

The clinical relevance is that these participants felt that psychological therapy is required in some form when helping individuals lose and maintain weight loss. They also recognised that support and education in obtaining a healthy lifestyle was also essential. This supports the earlier perspective that looking externally at strategies for weight maintenance is detrimental to the individual and further perpetuates their feelings of failure and isolation.

4.5 Isolation – Feeling Abnormal and Alone

Binge eating and compulsive overeating were depicted by participants as lonely, secretive behaviours. The negative cycles created feelings of self-blame; that there is something wrong with them they felt they are "*weak and stupid and just greedy"* (Linda, Line 284). As a result many of the participants felt that they are different from everyone else and this encouraged them not to share this shame. Participants spoke in terms of others being seen as 'normal' giving a sense of separation and difference from themselves as well as using derogatory words to describe themselves 'porky', 'fat boy'. Thus ensuring their isolation and suffering. The participants seem to be supported to some extent in their avoidance of discussing their weight by the behaviour of family, slimming clubs and clinicians. They all appeared to have what felt like a veil of silence around discussing the participant's weight or reasons behind the weight. Whether they fear offending the individual or perhaps they do not have the answers to help; this was unclear. This could be an area of future research. Linda still seems to have been left with confusion and regret around such a situation when she was looking for help even though she has now achieved long-term weight maintenance;

> "*I mean I was you know, 5'11" and twenty two and a half stone you couldn't really miss that there was a big physical problem….I don't know whether there was ever a reluctance because people were frightened to hurt my feelings or people did not make the connection that overeating could also be as dangerous as under-eating*." (Linda, Line 212)

Although Linda acknowledged that there appears to be more help now with overeating there is a sense that more needs to be done. These individuals who have experienced deep levels of desperation and have now maintained their lost weight have a strong desire for others not to suffer as they feel they did. They demonstrated their desire to help others through their actions and words. Reaching out to help others appeared to be another positive aspect of O.A. which helps individuals maintain their weight loss. This may be a way of encouraging the individual to gain a sense of wellbeing and self-esteem knowing that they are able to help others.

They found the government's message of 'eat less, move more' to be empty and judgemental;

> "*I'm not sure that the message don't eat as much is really not going to help anyone to not….a way of saying you need to do something but not telling you how, I'm not giving you any help to do that*." (Jane, Line 656)

There was also a sense of annoyance with the diagnosis and interventions given to anorexia nervosa and bulimia nervosa; with too few given to overeating. Participants identified the lack of control and powerlessness that they experience with food similar to the dependency that people have with alcohol or drugs etc. They felt the consequences of binge and compulsive overeating are as significant in severity. Two of the participants recognised that their dependency upon food could quite easily have been one of many other substances or behaviours and they felt it was only 'pot luck' that they ended up with food. Therefore clinical relevance for treating overeating may have some similarities with the treatment for addiction. They were trying to escape from who they were and food (or any other substance) would have fulfilled that purpose, it temporarily made them feel better about 'sitting with themselves'.

The message that these participants obtained from society is that severe obesity is not being taken seriously enough and that availability to successful treatments are limited. At the same time some individuals are limiting their own opportunity to seek help because the shame they feel from being different and lacking self-control from overeating is preventing and isolating them. More is needed to reach out to these individuals to reduce their suffering before their conditions becomes life threatening. Claire's shame prevented her from sharing her overeating with her 'normal' physician. It is questioned whether she would have found it easier approaching specialist weight loss services for help.

> *"It was so secret, I was so ashamed. The sense of shame I had was huge so to go to a normal doctor I just don't know how they do that but some people do but I couldn't do that*." (Claire, Line 587).

When Claire eventually went to see her G.P. she avoided the real reason for going and the physician did not ask about her weight;

> "*Um not very easily but I did yeah. The first time I went when I sat there and I realised I couldn't do that I couldn't tell anyone how I felt, I just started talking about my periods instead. I just couldn't I just could not say it."* (Claire, Line 593)

By gaining knowledge and insight about the individual with severe obesity using research like this, it was possible to determine the barriers and facilitators to each step to achieving maintained weight loss. This study was felt to be particularly beneficial in providing the comparison between those participants who had been on an N.H.S. programme with those from O.A., aspects of which will be looked at throughout this study. In seeking information from all of the participants they may feel that they are being taken seriously providing hope for interventions that meet their needs.

4.6 Seeking – Reaching levels of Desperation in Wanting Help

All of the participants highlighted that mental or physical ill health led them to begin their weight loss; two participants accessed an NHS weight management programme, one decided to lose weight alone and four participants joined O.A.

Each O.A. participant had reached a point of desperation in seeking and needing help and tried O.A. because nothing else had been successful. Having experienced commercial slimming clubs, physicians, dieticians, medication, psychotherapy, hypnotherapy, in-patient hospital stay they then tried O.A., even though some were hesitant due to the spiritual perspective of the Fellowship. They felt that they had no option but to attend. The four O.A. members felt that it was this level of desperation that was a contributory factor in adhering to the programme and recovering from overeating.

Sarah and David had both tried weight loss programmes previously but had not felt ready to engage therefore it is important to address what conditions would help the individual engage with an intervention programme. Sarah had attended O.A. but had not felt ready to openly discuss her problems; this is an aspect that is the decision of the individual. David had tried his first N.H.S. programme but it had not provided enough support; this is an area that intervention programmes can consider. What was identified is that each participant appeared to have reached a point in their lives where change was driven by necessity due to increasing physical or psychological ill health. Participants appeared aware that they were overeating but with little insight as to the reason(s) behind this.

4.7 Gaining – Obtaining Self-acceptance and Self-awareness

Lacking awareness of why the individual is overeating prior to successful intervention has been prevalent in all of the participants' interviews. The initial step towards weight loss was obtained from the support they received from the environment. The participants on the N.H.S. weight loss programme received C.B.T. and M.I. C.B.T.

allowed the individuals to begin to understand the connection between eating behaviours and how they felt and thought. In-depth psychological understanding of themselves was limited with little exploration into the reasons why they overate. O.A. participants appeared to gain deeper awareness of themselves by following the 12 Step Programme but it is questioned whether the participants really understood why they overate. Seeking the cause is discouraged in the O.A. programme which focuses more on moving towards a better life by daily reflection on their thoughts and feelings. The O.A. participants found that having a place to talk openly and honestly helped begin their process of breaking their cycle. The individuals said that they received a sense of inclusion , hope for a better future around food, identification with others and acceptance. By having the opportunity to understand that other people felt, thought and behaved as they did was what they needed initially.

> *"…..every single person who spoke it felt like they were inside my head. Um they, I didn't realise that other people thought and acted about food the way I did."* (Linda, Line 245)

The O.A. support continues through life as much or as little as that member wishes. By creating a community of like-minded individuals who provide support to each other, this aids recovery and helps maintained weight loss. Jane and David both wanted more support after leaving the N.H.S. weight management programme and have now both joined a form of volunteering within their community. This is of clinical relevance to aftercare from an NHS weight management programme.

Ian who lost weight by his own means does not appear to have had direct support other than from his family and speaking occasionally to a few work colleagues. He appeared to benefit from knowing that he achieved his weight loss by himself. Ensuring he was able to do it himself was an important element for him. Ian lost a lot of weight initially but his motivation appeared to be fading as his weight is increasing at a time when he has stressful life events. His reaction to the stress was to indulge himself in the foods that he likes; saying that he was treating himself. This is his decision but one which threatens any possibility of weight maintenance.

Within in the supportive environment of O.A. there is the understanding that the individual maintains their own autonomy and responsibility. Motivation has to come from the individual and if they decide, as Charles did, not to attend this is their choice as it is Ian's and they take responsibility for that. As soon as Charles stopped abstaining, his obsessions around food returned until he was able to abstain again. This indicated to him that he had to remain abstinent in order to recover;

> *"I could feel myself starting to to go, you know my head was was absolutely crazy as though before I I got abstinent with my foods my head was all over the place. Everything I was doing was all going to revolve around you know where we going to go to eat, what are we going to get for eating all that sort of stuff."* (Charles, Line 70)

As part of the O.A. programme the individual was recommended to abstain from the food that they feel is their 'addiction' and it is the individual who has to decide what they abstain from. The individual begins to gain a sense of control over their

decisions and actions whilst being supported by O.A. Giving up what you have depended upon for most of your life was a difficult prospect but abstinence has been evidenced to be attainable immediately by other group members. Charles was determined not to stop his abstinence again;

> *"If you're told you have to do you have to stop something for the rest of your life there's quite a panic…..you must be willing to go to any length which is what I was at the time you know…. That's every day of the week regardless of birthdays, Christmas or any special events. Never alter, never intend to."* (Charles Lines 62/540)

The change and motivation achieved by Ian and the four O.A. participants was evident. The O.A. participants had a desire to help and support others which is also what the programme recommends. In helping others they felt valued and wanted. Whilst there was little doubt these O.A. participants had been helped by the O.A. programme and they appeared to be autonomous and self-motivated yet at the same time there was also a strong dependency on the 12 step programme and the O.A. Group itself to ensure their weight maintenance. It is felt to be important to be aware of this dependency whilst accepting and appreciating that the participants accept themselves and are motivated to seek a healthier lifestyle. Charles and Claire both provide insight into changes in Self;

> *"I used to be very grumpy, very moody people couldna speak to me I would fly off the handle at them…. I was a loner type of thing I wanted to be on my own*

quite a lot – I'm full of life now completely and utterly full of life." (Charles, Lines 823/923)

"I was very much a Jekyll and Hyde really I suppose… I'd put on a big front for everybody but inside I was really quite depressed and unhappy but I never let anybody know – I'm much more open and I'm very very different…just much more real I suppose." (Claire, Lines 548/564)

The process of maintained weight loss was achieved through gaining self-acceptance and self-awareness which occurred in an environment that encouraged autonomy and responsibility to support the individual to abstain from their chosen food(s). This support could be continued for as long as the individual required it.

4.8 Analysing – Looking Objectively at your own Patterns of Thoughts, Feelings and Behaviours

4.8.1 Emotional Analysis

The supportive environment enabled the participants to begin to decide which food to abstain from. At the same time the individual gained positive mental health and self-awareness by analysing their emotions on a daily basis. Each participant in O.A. journaled daily how they felt; any negative events were analysed and looked at objectively. If the participant was unable to see another way of looking at their emotions they can seek support from a sponsor (another 'successful' member of O.A., this was presumed to mean one who had achieved maintained weight loss). This process allowed exploration of themselves on a regular basis to manage how they feel rather than using food to avoid their emotions. The participants learnt how

to manage their emotions. This is of clinical relevance for individuals who are using food to avoid emotions or seek to provide an emotional response from food; they could learn to manage their emotions and look at them objectively.

Sarah spoke of the difficult environment that she grew up in where neither parent appeared to regulate their emotions without the use of a substance. This may have prevented Sarah from learning how to regulate her own emotions. She said that she responded to everything with extreme emotions and that there was no middle ground. Sarah responded to food with no middle ground as did other O.A. members. Similarly Linda said that as a child she felt over sensitive;

> *"I felt like everyone else had some sort of instruction manual for life and that I just hadn't got my copy because I felt very over sensitive very emotional…things just touched me really hard, like very deeply um even as a young kid."* (Linda, Line 518)

Regular monitoring of her emotions prevented them from dominating her life and she was therefore able to live her life more successfully and peacefully. Sarah said she had a feeling of serenity in her life now which was in contrast to how it was initially.

4.8.2 Cognitive Analysis

It was found that both David and Ian focused on how they thought to help them find the motivation to lose weight. David talked of things '*clicking in to place (Line 498) 'getting it right in your head' (Line 72/451)* and he felt he benefitted from cognitive behaviour therapy (C.B.T.) which gave him some insight into his thought processes.

He also found the use of setting challenges and competing with others helped his motivation to reaching goals. Ian used a lot of self-dialogue to identify what motivated him; the cost or consequences of not losing weight. Both participants were now fluctuating in weight, with Ian saying he needed to prioritise his weight loss again to get it started. Ian and David both seemed to use an on-off approach to weight loss rather than a life-long way of living that was used by the O.A. participants to achieve maintained weight loss. Ian's levels of self-awareness were good with regard to knowing his levels of motivation but he appeared unaware of some deeper emotional responses. One example focused on how he responded with food to his emotions;

> *"…on the way back there is a McDonalds and I thought I'll call in there and I thought you know what I won't because I've won.* So if you hadn't of won*? Then I would have probably have been in there.* So what does that mean?*…..It's a bit scary, isn't it?"* (Ian, Line 794)

When comparing Ian and Linda's approach to self-awareness and their behaviour towards food; Linda also had very stressful life events yet her approach to life has changed. She was accepting of herself and her stressors and no longer used food to manage or treat herself;

> *"If there's any kind of strong emotion, if I'm very upset over something I'll write it down what it is I'm upset about and how, how it is affecting me…..and try an look at where I'm being selfish or dishonest or frightened….that's not to say*

that stops the thing being terrible or makes it alright….but it helps you look at things from a different viewpoint." (Linda, Line 834)

It was evident that Ian's strength of determination and the ability to use what motivated him had enabled him to lose a lot of weight but the focus now was about maintaining that weight. Having more insight into his emotions and the ability to understand them further may help him maintain his weight.

Cognitive insight into what motivated the individual is shown to be helpful in losing weight and using resistance around high calorie food, but maintained weight loss is achieved through emotional insight. Maintained weight loss also requires a life-long approach and cannot be treated in an 'on-off' way.

4.9 Choosing – A Day at a Time

Sarah, Linda and Charles were all abstaining from certain foods and had managed to maintain their weight loss. They abstained one day at a time and in doing so stayed in the present moment. They did not dwell on the past or think too far into the future and this helped them cope with the feeling of loss from not having the food they crave in their lives, so that they did not feel overwhelmed. There was a sense of seriousness about the mental attitude that is required when entering into abstaining. There was also a very clear emphasis that having the occasional treat of the foods you compulsively eat should not occur if you wish to stay well. This was expressed by Linda;

> *"I think that's the difference that there's people like me all around the country that are being told by diet clubs and probably their doctors and everybody you know it's ok, just have a treat once a week but people like me can't have a treat once a week, it's not a treat…it's poisonous to us and it's really damaging to our heads as well as our bodies."* (Linda, Line, 405)

This goes against the recommended advice provided by many interventions where moderation is permitted. The difficulty of abstaining from certain foods has been highlighted and was something the participants found very difficult to maintain. Linda stated that sugar was really difficult to avoid. Sugar is presented in high quantities in many foods but is not obviously apparent. She had to be constantly vigilant not to trigger her overeating off by accident. This is an area that could be helped by government assistance promoting clear, concise labelling of food products.

The participants often compared what they saw as their addiction to food with alcoholics or gamblers. The difference being that for an alcoholic or a gambler avoiding their substance/behaviour altogether is easier because your body does not need them to survive as it does with food. Abstinence needs constant awareness by the individual. The participants managed their abstinence by providing their sponsor with details of their daily food intake. From this research it appeared that for individuals who are severely obese, abstinence is required to achieve stability and maintained weight loss. It is questioned whether the same advice would work for those who were overweight or obese and looking to lose weight and maintain. By not having reached the same level of desperation they may not be at a stage where they are willing to do anything to gain stability over eating. The four participants who

attend O.A. appeared to be adamant that it was the group and the programme that helped them achieve abstinence and it was only by continuing to do both that they will maintain. This appeared to provide evidence of a level of dependency to the group and programme which may limit an individual's autonomous recovery. The reflection of the participants' emotions and dietary intake which were shared with their sponsor initially on a daily basis appeared to be reduced over time with some participants. This seemed to be a steady process which may facilitate the individual to become more autonomous over time. Further research would be required to determine whether O.A. members are dependent upon the group or use the group purely for support purposes when they have achieved independence.

The participants' lives had been changed for the better and their desire to help others is continued through the new group members. Claire expressed what the experience meant to her;

> "*It wasn't just about the weight ever it was about me and inside me."* (Claire, Line 555)

4.10 Summary

The findings allowed the construction of a storyline showing the process that the participants experienced to achieve maintained weight loss. This was identified in seven categories culminating in the final category of 'Emergent Self'. The emergent self revealed that the individual had developed greater self-awareness and acceptance through the conscious knowledge of their own character, feelings, motives and desires. Greater self-awareness allowed the individual to begin to

change their relationship with food and manage their emotions in a more constructive way.

Childhood experiences were a prevalent antecedent of obesity reported by the majority of participants. Further research would be required to identify a precise picture of mechanisms involved in translating childhood patterns into adult thoughts, feelings and behaviours. As adults, participants avoided their emotions and thoughts which resulted in negative cyclical patterns of behaviour around food. Consideration needs to be given to government recommended interventions which may exacerbate these negative cyclical patterns and escalate their obesity further. Successful maintenance of weight loss for these participants was established through greater psychological awareness and self-acceptance which provides clinical relevance. The environment provided constant support which encouraged autonomy and responsibility. Maintenance of weight loss depended on completing a 12 step programme which encouraged acceptance, abstinence and daily emotional reflections. Together these strategies provided constant reflection, reassurance and a strong desire to continue improving themselves and helping others. All of these factors provided an understanding to what facilitated the participant's maintained weight loss and reflects areas for clinical implications.

To culminate the findings there is a short summary below of the significant barriers and facilitators to maintained weight loss identified in this section. The findings will be elaborated on in the discussion where consideration will be given to comparing them with the current literature on theoretical explanations and interventions.

4.10.1 Barriers for participants to achieve maintained weight loss;

- **Control** – controlling every aspect of their life.
- **Avoiding** – avoiding difficult emotions or negative thoughts.
- **Lacking Openness** – being secretive and not seeking help.
- **No Support** – not using or having insufficient supportive structures.
- **Lacking Insight** – being unaware of deep emotions.
- **Lacking Acceptance** – lacking self-acceptance.
- **Lacking Seriousness** – not committing to change.
- **Blaming** – the individual being and/or feeling blamed.
- **Stigma** – experiencing stigma or stigmatising others.
- **Individuality** – not having their personal needs acknowledged.

4.10.2 Facilitators – the participant needed;

- **Honesty** – to admit to being powerlessness over food.
- **Hope** – to know that there was another way of being.
- **Identification** – to know that they are not alone.
- **Openness** – to not need to remain secretive.
- **Support** – to be supported in every step of their experience.
- **Autonomy** – accept responsibility without blame.
- **Self-awareness and Acceptance** – to work towards these processes.
- **Seriousness** – choose a life-long way of learning.

Chapter 5 - Discussion

5.1 Introduction

The aim of this study was to provide insight into what facilitated maintained weight loss from the perspective of individuals who have achieved this aim. The findings suggest that with greater self-awareness and acceptance the individual was able to understand themselves at a deeper level. This provides the individual with the ability to understand and manage their emotions to a greater extent without the need to avoid them. The findings raised clinical implications for current weight management guidelines and future interventions; these will be discussed along with the relevant literature.

5.1.1 Control and Emotions

A central process that resonated throughout these interviews was that of trying to maintain control and avoid a loss of control. There was a fear of feeling negative emotions which threatened to overwhelm the individual and they therefore sought to control their emotions by using large quantities of food. When the level of food became overwhelming accompanied by a feeling of loss of control the individual would then seek to control the food by focusing intensely on external objects. Using different means of control meant that the individual was continually attempting to avoid what was occurring internally with their emotions. Avoidance of emotions was a significant factor in the difference between those who had maintained weight loss and those who had achieved 10% weight loss but were still fluctuating. O.A. was a significant focus for this study because the participants who had achieved maintained weight loss had completed their 12 step programme and therefore it was important to identify what facilitated this. The other participants also brought significant insight into facilitators to weight loss and the barriers that prevented

maintenance. Facilitated maintained weight loss was obtained through improving self-esteem and self-awareness by asking participants to write out their life history and share their feelings with their sponsors. By focusing on the individual, their life events and the way that they are perceived allows for greater personal insight and enables the individual to manage their response to their emotions in a more positive way. These findings are supported by Buckroyd (2011) who identified that some individuals use food to manage their emotions as a coping strategy and an emotional dependency to life stressors. This explains why recommendations to reduce or stop food without looking at the underlying reasons are very difficult for the individual to do. The difficulty of reducing food is supported by Owen-Smith et *al*. (2014) who identified that individuals who had bariatric surgery and were therefore forced to adjust their eating habits suffered psychological distress because their emotional response to food had not been addressed. Reducing and stopping food intake without addressing the underlying psychology has significant clinical implications for weight management recommendations and intervention. These findings validate interventions that explore deeper meanings to overeating and provide the opportunity for greater psychological interventions to weight management.

5.1.2 Commercial Slimming Programmes

The findings from this present study identified that commercial slimming clubs were found to assist in providing an illusion for individuals of being in control and encouraging obsession over food. The participants identified a vicious cycle perpetuated by commercial slimming clubs that demoralised the individual by setting targets which the individual would either achieve or fail. Feelings of failure would contribute to the individuals' negative emotions and view of themselves which has

been identified as being detrimental to achieving maintained weight loss. Similarly commercial slimming clubs and some weight management programmes promote diet and exercise through reducing, monitoring and controlling the food intake and monitoring increased exercise. This is understandable to some degree when the aim is to lose weight, the obvious approach is to eat less and exercise more. It is also in line with N.I.C.E. (2014) guidelines for treating obesity. This study's research findings showed that the participants who had achieved maintenance from being severely obese were unable to sustain weight loss long-term when being instructed to eat less. This is because the underlying reasons to their binging and compulsive eating were not considered, understood or altered. The participants indicated that initially it was possible to follow instructions to reduce food in the short-term. They indicated that this was because it was another way of controlling their eating, however if long-term weight maintenance was to be achieved it was essential to change the individual's attitude. This is vital information because the recommendations by N.I.C.E. (2014) are advising physicians to send obese individuals into this vicious cycle. The cycle not only encourages weight gain in the long-term but can also negatively impact an individual's mental health. This is perpetuating the individual's cycle of weight gain and emotional distress and actually providing them with the means of becoming severely obese. An alternative intervention for treating individuals with severe obesity is to use psychological therapy that considers how an individual regulates their emotions as well as encouraging greater self-awareness and acceptance.

5.1.3 Acknowledging Powerlessness

This study's findings identified that on commencing the O.A. programme the participant acknowledged that they had no control around food; that they were powerless over food. This was something each person openly acknowledged to themselves and others. It is questioned whether this is addressed openly in weight management programmes or is it assumed due to their referral there. This acknowledgement by the participant appeared to be important in contributing towards achieving maintained weight loss and should be considered essential when commencing a collaborative relationship between the client and clinician. If this is not openly discussed it is questioned whether the individual remains dependent on the clinician for external motivation, rather than being intrinsically motivated to work with support towards their physical and psychological well-being.

5.1.4 The Importance of Self-esteem

A few of the participants acknowledged traumatic events in their childhood and teenage years supporting research by Hughes et *al.* (2005), that trauma can result in a vulnerability to responding constructively and objectively to negative emotions as adults. Others appeared extremely sensitive to outside influences; this supports research by Heatherton and Baumeister (1991) that identified individuals as having difficulty managing the expectations of others. This results in feelings of being a failure and having low self-esteem. Feeling extreme sensitivity and having a fear of failing were identified in the study's participants, who avoided these feelings by overeating. Future research studies could obtain a detailed childhood history of individuals with severe obesity and begin to identify this connection further. Low self-esteem, binge and/or compulsive eating and poor mental health create what

Owen-Smith et *al*. (2014) defined as a vicious cycle, stating that it is difficult to change. Each individual requires the motivation to change which is difficult with low self-esteem. Buckroyd (2011) recommended working on improving an individual's self-esteem prior to establishing any change in their food intake. This has the intention of helping the individual to feel they can manage their emotions in a more positive way and boost self-esteem which encourages intrinsic motivation.

5.1.5 Intrinsic/Extrinsic Motivation

Interestingly motivation initially appeared to be obtained externally in O.A. which was in contrast to research by Ryan and Deci (2000) who suggested that the individual needs intrinsic motivation for change. The external motivation came from the participants seeing that the facilitators of O.A. had what they wanted; peace around food. The O.A. members provided hope that it was possible for the participants to achieve this if they followed the same programme. This was obtained by working in a quasi-psychological manner using the 12 step programme as well as gaining inspiration and identification from listening to others about their experience of achieving maintained weight loss. This supported research by Sobal and Stunkard (1989) that placed emphasis on the individual being autonomous and intrinsically motivated to continue maintaining their weight loss after leaving the weight loss programme. Therefore having extrinsic motivation to engage the participant and intrinsic motivation to continue the weight maintenance are essential. Therefore intrinsic motivation was difficult to determine but group cohesiveness appeared to be related initially to extrinsic motivation. Weight management programmes would benefit from involving individuals who have achieved maintained weight loss and are

willing to openly share their experiences to assist the delivery of a weight management programme.

5.1.6 Autonomy, Competence and Relatedness

Maintained weight loss was facilitated in this portfolio's findings by ensuring the participant's autonomy at all times. Ryan and Deci's (2000) self-determination theory identifies that autonomy, competence and relatedness are the fundamental principles that support an individual's basic psychological needs. All of which were significant facilitators to the participant's maintained weight loss. Participants were able to demonstrate their autonomy by choosing whether to engage in the programme, deciding their own eating plan, which foods to abstain from, writing their life history, ensuring they made amends, supporting others and choosing to remain in the programme. The participants initially acted according to their own interests within O.A.; they wanted 'peace around food' and they were working towards achieving this aim.

Abstinence was obtained gradually by experiencing this positive environment which provided constant support and positive feedback. They began to obtain a feeling of mastery over their life, something that they had lost when they compulsively ate. Participants reported getting their life back.

Ryan et *al*. (2003) stated that relatedness refers to a wish to be connected and a feeling of belonging found within a warm and caring environment. This was one of the strongest facilitators for maintained weight loss identified within this study. The participants were able to privately share their life history with their sponsor whilst on the programme and obtain continued motivation and support in their lives from the

group. Ensuring adequate support both during and following an intervention programme is a significant gap in treatment and questions the way that current treatment is run. N.I.C.E. (2014) recommended that severely obese individuals are placed on a weight management programme. This may run for an allocated number of weeks where they have the opportunity to lose weight through healthy eating and exercise, possibly accompanied by psychological therapy after which they are then discharged. Two of the study participants who had finished an N.H.S. weight management programme both identified that support was essential and helpful. The participants received support whilst on the programme but it stopped when they finished the programme; this was particularly unfortunate because they were only just beginning to lose their weight from a B.M.I. of Class III. Support was a key area that both participants wanted more of, whilst at the same time acknowledging that it was important that they did not become dependent upon using it.

This research questioned whether the level of support provided by the O.A. sponsors may be detrimental to emotional independence. They adhered to daily self-reflection and awareness of their emotions as well as planning what they were eating on a daily basis; both of which were given to their sponsors. This is a very intensive approach to begin achieving maintained weight loss. It is acknowledged that this dependency may change over time as the individual becomes more self-aware and accepting; only further research could identify any such changes. Most importantly some participants did not appear to be aware of the processes to why they were doing the 12 Step programme, responding purely to what was asked of them and knowing that it stopped them from overeating. Ideally the participants would be aware of what the process was providing them with and to work on the skills to

achieve it themselves, whilst being aware that sponsors and the group are there to support them should they require it. This may come from formal training in working therapeutically with individuals.

It is clear that social support is essential; it is therefore felt that forming communities of like-minded people who are able to provide support is beneficial for maintained weight loss.

5.1.7 Achieving Abstinence

The clinical guidelines recommend diet and exercise for the treatment of obesity; therefore it is important for clinicians to recognise the theoretical explanations for lack of adherence to a diet and exercise regime. A number of theoretical explanations for overeating that have been proposed are; external eating (Snoek et *al,* 2013); overriding attention bias to food cues (Hou et *al,* 2011); overriding internal food cues (Fairburn & Brownell, 2002); genetic predisposition to obesity (Wilding, 2011) and an instinctive biological urge to survive (van Buren & Stinton, 2009). It is questioned how with these potential barriers were the individuals in this study able to abstain immediately from certain foods. This study's findings found that they initially identified with the hope, honesty and openness within the supportive environment. They were autonomous and willing to follow the programme because they wanted peace around food and could see the programme worked. External and then internal motivation helped the individual to instigate their abstinence which was then reinforced by completing the psychological approach to the programme. The participant obtained positive mental health with an understanding of their past and present life events, acceptance, forgiveness and self-awareness. This supports

Buckroyd (2011) in the recommendation of treating the psychological perspective first.

5.1.8 Psychological Intervention

As an approach to treatment, Buckroyd (2011) recommends focusing on improving the individual's emotional intelligence, self-esteem, body esteem, relationships and self-soothing prior to changing their food intake. Individuals who achieved maintained weight loss also looked at some of these aspects; emotional intelligence, self-esteem and relationships. O.A. encouraged these aspects in individuals and promoted them day to day within their supportive community. Whilst it is difficult for weight management programmes themselves to provide intensive support within the community, they could encourage successful individuals once they leave the programme to provide a supportive community of like-minded individuals. Many of the psychological aspects recommended by Buckroyd (2011) are included in dialectical behaviour therapy. D.B.T. is recommended in the N.I.C.E. (2004) guidelines and adapted for use with binge eating. Even though D.B.T. is recommended for B.E.D., which in itself limits its use to this group of individuals only, it is also unknown how many specialist centres or weight management programmes implement its practice.

The Health at Every Size (H.A.E.S.) model is also comparable to the recommendations of Buckroyd (2011) and the O.A. concepts which focus on the psychology of the individual first and foremost. The foundation of the H.A.E.S. model is to achieve positive mental health, quality of life and self-acceptance for the individual. The model focuses on the individual and does not consider dieting or exercise until the individual is self-motivated in wanting to change their food and

exercise. Alternatively the N.H.S. uses the medical model which focuses on the physical symptoms and finding treatments for them which is why the primary focus is on reducing weight in the severely obese. In order to reduce comorbidities and general ill health associated with severe obesity, it is felt that the individual needs to reduce their size, and weight is the obvious focus. What this study's findings have shown is that weight is not the primary concern for these individuals with severe obesity. They shared that they were suffering from psychological distress which became progressively worse as a result of the negative cycles created from the help they attempted to seek. This therefore questions whether a change of approach to weight management should be considered, for example the H.A.E.S. model; one that does not directly address weight but focuses on an individual's psychological wellbeing.

5.1.9 Stigma and Blame

Puhl and Heuer (2009) identified that weight related stigma is experienced in many areas of a severely obese individual's life for example, social, employment, education and health care. All of which can impact negatively on the individual's self-esteem, placing barriers to treatment. Sikorski et *al*. (2011) suggested that stigma is helpful in motivating the individual with severe obesity to change but the findings from this study disputed this and stigma was found to have the opposite effect, for example, the first two participants from the weight management programme used external reasons for their lack of weight loss which was thought to indicate perceived stigma and blame from society. This indicated an external locus of control by stating that their weight gain was due to reasons beyond their control. Their lack of weight loss then becomes a negative focus. This highlights the subtle

difference between the individual feeling blamed and trying to defend themselves with one of the individual accepting responsibility for their actions but requiring help and support and the insight to change. The latter was found to facilitate maintained weight loss.

None of the participants in this study reported any stigma or blame from the health care professionals which contradicted research by Puhl and Heuer (2009). There was unwillingness from one participant to receive advice from a severely obese health care professional, this supported Puhl et *al*'s (2013) research; that practitioners should lead by example. The main area for concern was the participant's significant difficulty in accessing mental health therapies due to long waiting lists in addition to difficulty finding effective treatments for weight maintenance.

The participants felt strongly that their condition was not being taken seriously enough by society and they had to reach levels of desperation in finding an intervention that worked. Change needs to occur from those with the most influence on society and this starts with those in government setting the standard for others, without prejudice, discrimination or stigma. Participants in the study felt that the government's message was judgemental and detrimental in supporting individuals with severe obesity. This attitude ostracises individuals from society and encourages them to form separate support systems rather than feeling accepted and being able to integrate fully into society.

5.1.10 Obesity and Addiction

Although severe obesity has not been identified as an addiction the participants in this study felt that they were addicted to food. They felt that their loss of control around food was something that they were unable to stop by themselves and that their craving for food increased over time. In support of the participants' feelings around being addicted to food Nijs et *al.* (2009) identified that the neurological loop reward system was similar in individuals with addictions and overeating. The participants felt that although they had abstained from certain foods they still needed to work one day at a time to keep their abstinence. This was in addition to being in constant contact with O.A. for support and assistance should they experience cravings. Participants felt strongly that they had an addiction. This condition needs to be taken more seriously than it presently is by society, the medical profession and the government. It is considered that severe obesity has afforded more recent attention due to the increasing costs of treating comorbidities, particularly Type 2 diabetes rather than the suffering that has been identified in this study which occurs on a daily basis. This type of research emphasizes how difficult it is for individuals with severe obesity to achieve weight loss and then ensure maintenance through constant emotional analysis every day, something that other individuals may take for granted.

5.1.11 Attitudes to Exercise

The findings identified that participants understood the importance of exercise and they identified with the benefits of feeling fitter, yet initial adherence to an exercise regime was temperamental or not at all. This was supported by Shaw et *al*. (2008) research which showed high attrition rates. Those who had not maintained showed

fluctuating on and off approaches to exercising. They stated many reasons for not exercising from medical conditions preventing them, not having enough time, poor weather, putting other things first, to not wanting to 'see a fat boy run'. The individuals who had lost a lot of weight said their difficulty had centred on not wanting to exercise in public due to perceived stigma which supports Lewis et *al*. (2011) research. The clinical implications show how difficult it would be to encourage individuals with morbid obesity to exercise; consideration of specialised classes may encourage motivation and create unity and identification. Their all or nothing approach to life was revealed in their approach to exercise, for example, they soon stopped intense bursts of exercise because they felt that the amount of food they consumed would not be counteracted. By stopping any form of exercise regardless of weight loss individuals are not receiving the benefits outlined by Powell and Pratt (1996). Once again the symptom of severe obesity was trying to be treated and not the underlying cause.

Walking was a popular form of exercise because participants felt they could accomplish it without stigma or feeling demoralised. The participants who had maintained weight loss found their enjoyment in other forms of exercise which they commenced when they felt comfortable to do it in public. They exercised when they were fitter and therefore found them more enjoyable. This supported the H.A.E.S. model of addressing weight loss presented by Miller & Jacob (2001); that exercise should be enjoyable and a matter of individual choice. This study found that exercise was addressed when the individual felt emotionally and physically capable which again provides evidence for not focusing on exercise as an initial target for weight loss.

5.1.12 Differences in Sexes

It was noted in this study that the male participants seemed to want different approaches from their process of losing weight compared to females. One participant knew he needed to see a quick result in his weight loss, thought to ensure motivation and a sense of achievement. The individuals who maintained weight loss said that they did lose weight quickly and naturally without exercising at the start of their programme. Clinically this provides evidence that once the intervention is working, in this instance improving their mental health, then weight loss is a secondary benefit. The participants, who maintained goal weight in this study, emphasized that speed and weight loss was not their primary focus unlike the participants on a medical model programme. They wanted a change in their eating habits for life and their focus was on abstaining from the foods they felt made them binge or eat compulsively. It was identified that two of the males wanted to be independent and achieve weight loss themselves. This appeared to stem from obtaining a sense of achievement from managing weight loss alone and the other was focused around maintaining a macho image. The male participants disliked going to a group, particularly of all females, to lose weight which supports the work of Jolly et *al*. (2011). Even though one of the male participants wanted independence initially, he was later seen to benefit from group support and is now helping others, particularly men in a group. These are important considerations when seeking to engage and maintain men in weight management programmes.

The use of technology was not gender specific. The participants who had not maintained were the individuals who spent a lot of time and energy on using information technology (Apps, spread sheets, Fit bits etc.). Whilst Spring (2013)

recognised that technology in weight loss can be useful for some individuals who like to work independently, it was not constructive for the participants in this study. This provides an individualistic approach to weight loss but for weight maintenance this study's findings found technology to be unnecessary and may be used for emotional avoidance.

5.2 Implications for Practice

The main findings from this study have provided insight into the facilitators and barriers to maintained weight loss. The findings asked questions of various aspects of the recommendations presently used for weight management. The implications for clinical practice focus significantly on the provision of psychological therapy and a reduced focus on weight loss. The individual improves psychologically because their underlying cause for overeating, the inability to manage their emotions, has been addressed. This research questions the present medical model in its approach to treating severe obesity by referring individuals to weight management programmes that are purely weight and exercise focused. Although psychological therapy is presently recommended as an intervention for B.E.D. its availability and efficacy are unclear. The focus on weight and calorie reduction was also found to be providing the individual with a means of avoiding their emotions and in the long-term encouraging weight increase. The study's findings identified that by addressing the individual's perspective to negative life events and improving the participant's self-esteem these aspects then contribute to a change in their attitude towards themselves and society. This change combined with a supportive environment enabled the Individuals to gain emotional regulation and abstain from the food that they once had no control over.

The clinical implications from this research suggest the individual receives one to one psychological therapy in addition to collaborative group work with a focus on D.B.T. skills. The aim of group work would be for support and to encourage self-acceptance, learn self-soothing and mindfulness for emotional awareness and distress tolerance. The findings identified that by encouraging individuals who have

already achieved maintained weight loss to attend group sessions, this would provide an opportunity to identify with the other attendees and enable new members to gain hope for a healthier life. Findings identified that clinicians need to be well trained in presenting the psychological therapy and confident in its success so that attendees believe that the intervention will work for them if they adhere to it. It was also beneficial to individuals attending a programme if the clinicians lead by example. Throughout any weight management programme intensive support and education is required with continued support being provided after leaving the programme. The continued support could be provided by the group members forming a community group or internet group for like-minded individuals. In the study's findings, implementing these interventions provided the conditions for the individual to achieve abstinence and the motivation to continue with daily emotional regulation. The recommendations detailed here are documented in the hope of positively influencing clinical practice or informing professional decision making for future management of severe obesity.

An increase in research is required in many areas of severe obesity. This study identified that a greater understanding could be obtained about the aetiology of severe obesity by focusing on the childhood relationship between the participant and main caregiver. This was with reference to their attachment style and the use of food in this relationship (Bowlby, 1997). This is an area that has been researched in obese individuals but it is felt that greater insight would be beneficial for severely obese individuals in connection to extreme emotional sensitivity. This study also identified the need to obtain greater understanding of the participant's adult relationships with close family members. With reference to understanding how the

secrecy and shame that the participant maintained over many years continued without seeking help from their family. It is felt that greater understanding may help communication and prevent the participant's isolation from society and possibly their own family. Research would provide greater understanding and knowledge to help society help the individual.

5.3 Summary

The overarching findings obtained from this research with regard to facilitating maintained weight loss converge towards the core category of the 'Emergent Self'. Recognising that by addressing the individual's underlying psychology behind their disordered eating facilitates change for greater self-awareness and greater self-acceptance. The resulting psychological growth provides the individual with the ability to manage emotional distress creating a sense of setting the individual free from the interpretations they have formed about themselves. Change is possible and can be facilitated in a supportive, non-judgemental environment which encourages open and honest bidirectional dialogue between the individual and facilitator whilst working towards maintained weight loss.

Chapter 6 – Critical Appraisal

6.1 Introduction

This Chapter will address the strengths and weaknesses of this study and how they may impact future research. It will also consider my reflections over the course of this study. The reflexivity will focus on the impact that this research has had upon me as a novice researcher and counselling psychologist and how I can use the information in the future.

6.2 Constraints of the Study

The change of inclusion criteria which provided strength to this study may also be identified as a weakness because it tightened the criteria and limited the availability of recruiting new participants. . Extensive recruitment strategies were undertaken with numerous sources contacted but responses were limited. Details of all the contacts have been indicated in the methodology chapter.

The study began with inclusion criteria of intentionally losing 10% from the baseline weight with individuals who had started their weight loss with a BMI of 35 or above. Ten per cent maintained weight loss was found to reveal a means of losing weight but not sustaining maintained weight loss. The first three participants were fluctuating in weight and they were therefore unable to evidence maintained weight loss which this study required. Therefore the criteria were changed to include participants who had achieved and maintained their goal weight. As a consequence the difficulty of recruiting participants increased. This was thought to be due to difficulty of achieving maintained weight loss from severe obesity and/or the reluctance for individuals to come forward and reflect upon once being severely obese. O.A. participants are encouraged to focus on achieving maintained weight loss by staying connected with their Fellowship at the same time as supporting

others to achieve maintained weight loss therefore they were more open to discussing their maintained weight loss . The limitations of the revised inclusion criteria resulted in a small study for grounded theory, with the majority of successful participants originating from the O.A. programme. The size of the study does not detract from the valuable data provided by the seven participants and the resultant grounded theory. A strength of the study came from being able to compare and contrast all of the participants. Each participant provided valuable insight into the facilitators and barriers to weight loss however maintained weight loss remained particularly evident for the O.A. participants. O.A. has a much prescribed way of working to the 12 Step programme which may appear restrictive in many ways it is also shown to be successful for helping these participants achieve and maintain their weight loss. NHS interventions appear more diverse across differing programmes which may make identifying overall what worked for individuals difficult to evaluate. This limits clarity in replicating successful interventions on a larger scale.

Future research could source the participants according to the amended inclusion criteria to ensure the availability of successful participants to focus on what facilitated maintained weight loss on a larger scale.

One of the participants Claire, had a BMI of 31.6 (Obese Class I) which did not meet the entire inclusion criterion. She was included into the study because it was felt that she provided an excellent example of maintained weight loss over a prolonged duration of time, totalling 18 years. She had achieved this by her continued attendance at O.A. and she provided a very honest and open interview about her experiences of being obese to maintaining her current normal healthy weight.

I was aware of the A.A. programme but was not fully aware of the 12 Step structure that individuals complete and which appears to be the foundation to each A.A./O.A. programme. I had not heard of O.A. until the third participant interview. After completing the interviews and this research I am left both admiring the humanistic underpinning that the programmes appear to have at the same time as being reserved/cautious about some of the structures to the 12 Step programme.

I have mentioned the strict guidelines that O.A. members are asked to follow which appeared to contribute to maintained weight loss for the participants in this study. Whilst providing support for each individual and hope and encouragement for new members, O.A. also advises members not to look back and question why they were overeating. I was left with a feeling that the participant's lack of questioning the reasons why they became severely obese may limit their recovery. I also questioned how some participants were unaware of why they were doing daily self-reflection around thoughts and feelings which was felt to limit enhanced self-awareness. As a counselling psychologist I was also very aware of the high ethical standards we are required to adhere to in this profession and for which we have a regulatory body to ensure that no harm comes to the clients. It provides an opportunity for complaints or concerns to be heard. O.A. does not appear to have such a body yet is asking members who may have no formal therapeutic training for such work to help new members through a very traumatic and emotional 12 Step Programme. Even with these questions I was aware that this programme worked for the participants both in achieving maintained weight loss and helping them when they desperately sought some form of help. By highlighting some constraints that this study experienced and recommendations on how to overcome these constraints, it provides knowledge for future studies wishing to undertake similar work. This research has provided

detailed insight into the participants' experiences, identifying the facilitators to maintained weight loss, the details of which can be compared with other qualitative studies in the area of maintained weight loss to gain greater understanding and work towards successful interventions.

6.3 Reflexivity

When considering what topic to do for this research I felt drawn to focus on obesity which is very prevalent within society. I had not worked in the field of obesity which on reflection was felt to be beneficial in that I had very little preconceived ideas and knowledge of weight management programmes and interventions. I had some personal knowledge of obesity which I felt provided some insight into the struggles with weight management. It is recognised that the experiences that I have had will affect this research to some degree, as Burr (1995) suggests we are a product of our cultural and historical background. We cannot remove this culture and history from ourselves as this underpins our knowledge of the world. Whilst it was felt that my own interest in weight management had been of benefit to the aims of this study I also wanted to ensure openness in this area and as part of the grounded theory methodology I used memoing and reflexivity. I was also new to grounded theory analysis, whilst having experience of other forms of qualitative and quantitative research as an undergraduate. I found using grounded theory allowed my experience as a trainee counselling psychologist to be overtly influential in the interpretive process of forming a theory grounded in the data.

I naturally gravitated towards the individual with severe obesity; this was mainly due to feeling a desire to understand the person more as well as the condition. I felt that the stigma attached to individuals with severe obesity was unfounded and I had an opportunity to gather information to provide insight and hopefully educate negative attitudes. As an undergraduate I chose to research those individuals who had chronic fatigue syndrome [C.F.S.] (myalgic encephalomyelitis) another condition that was surrounded in scepticism and judgement principally due to its unknown

aetiology. Sometimes our objective views can become judgemental and lacking in empathy for the person and as a result creates a barrier between providing the person with the support and resources that they need to recover. I felt it is my responsibility as a counselling psychologist to ensure that I remain open to understanding another's perspective and that this research would help in this aim.

Charmaz (2006) suggests that a reflexive stance informs how the researcher contains his or her research, relates to the research participants and represents them in written reports. To adhere to this important aspect of reflexivity in grounded theory I have written reflexive pieces prior to attending each interview and immediately following each interview to capture as near as possible both reflection in action and reflection on action (Schön, 1983). Additionally I have written reflexively after analysis of each interview to ensure openness from my perspective.

I knew my research had begun when completing the I.R.A.S. form for N.H.S. ethics. The level of depth required allowed me to fully understand my research as well as recognising what a vast topic I had chosen. By narrowing this broad area down to focus on severely obese individuals within the UK this allowed a more in depth perspective and showed me how limited the previous research in this area was. The I.R.A.S. report felt at the time to be a considerable undertaking but one that I approached with guarded enthusiasm. Initially there felt to be many areas that were out of my control; seeking ethical approval at three different points, obtaining participants from an N.H.S. Trust that had a deadline which I had to meet and waiting for participants to respond. Wanting to begin the research but being dependent upon others was found to be challenging but it helped me develop skills

of being proactive in areas that I could action, being patient in other areas as well as working to deadlines.

When N.H.S. ethical approval was obtained I began the process of recruiting participants. Ideally I wanted individuals who had left their weight loss programmes because at the time I felt that this would provide a clearer indication of the individual maintaining their lost weight. I felt they had to lose weight independently. This research has taught me that to have some form of support is perhaps what individuals require in order to maintain their weight, and that they do not have to do it alone. This knowledge helped me recognise that my initial assumption was incorrect.

Recruiting participants who met the revised criteria proved to be more difficult than I had first anticipated. I knew of two people who were asked but did not want to take part in the research; no reasons were provided. I thought that the individuals may not wish to recognise or talk about what being severely obese meant to them once they have managed to move away from this condition altogether. Both past and present research has shown how negatively individuals see themselves and are seen by others when severely obese. The decision to change the inclusion criteria was carried out without question because I felt that the aim of the study was not being met.

As I interviewed the last three participants I recognised that I was at a disadvantage when completing the telephone and non-video Skype interviews. This was because I was unable to see the individuals and any non-verbal cues were inaccessible.

Hogg and Vaughan (2002) note non-verbal communication goes largely unnoticed, yet it has enormous impact, as it did for me. My work entails face to face sessions with people and I had not realised just how different an interview over the telephone would be. I took time to adjust to understanding how a person is feeling and responding through speech alone whilst in the process of the fifth interview. As a consequence of which I felt the interview was slightly staggered but at the same time obtained some valuable insight into maintained weight loss. A strength of interviewing without the participant seeing the interviewer, is that the participant is unaware of the size of the researcher; which may have presented bias or expectations and therefore influence what was said.

My initial thoughts after completing and transcribing the interviews for the first two participants were that they did not appear to show anything new compared to the existing knowledge that I had; that maintained weight loss was obtained through diet and exercise. This was disappointing because I felt that there was a psychological underpinning to maintained weight loss. I was very aware of placing my expectation on to the data when it may not be there but the process of Charmaz's grounded theory ensured that the theory arose from the data. Being new to analysis using grounded theory I was concerned that because there was no rigid, systematic way of working I would find it difficult to follow. Fortunately it worked to my advantage because it felt a natural process to use inductive strategies for comparing and analysing the data and I was able to remain interactive with the data rather than an objective researcher.

As I made my reflections prior to and following the interviews, my general perceptions identified that both of the first two participants had low self-awareness particularly with regard to their emotions and self-concept. The data was focused on the tools they used and the reasons that prevented them from losing weight. The only aspect of the first interview that surprised me was the participant's suddenness of her emotions and the haste in which she dismissed them, something I reflected on post interview. At the time the results of these two interviews made me question the value of this research. I then interviewed the third participant and the difference to me was striking. I felt that she was someone who knew in depth about herself and that she was in total contrast to the first two interviewees. Unfortunately she was still not an example of stable maintained weight loss. I recognise that my training as a counselling psychologist would have helped me identify the differences between these three participants which I see as a benefit to this research but I could not know indefinitely until the data was analysed. The reason I chose to do line by line, gerund initial coding also ensured the process was being observed in the data. An interpretation of the participants' meanings and social constructs of maintained weight loss could then be obtained from the data; this I felt had been demonstrated in this work to produce a substantive theory to maintained weight loss. Finlay (2002) suggests that reflexivity should be used as a springboard for greater insight, which I felt it was. Experiencing this feeling of my research lacking an original discovery allowed me to become grounded in my expectations and curb any naivety around my research. Whilst allowing me the opportunity to feel privileged that these participants had provided deep insight into their own personal constructs of weight loss and maintenance. It was felt to be extremely important to have their

experiences heard and most importantly to enable the seriousness of how they felt to be acknowledged through the process of interviewing and analysis.

I feel that this research has broadened my insight into understanding the lives and challenges of being severely obese and the difficulty of achieving and maintaining weight loss. I feel that further research is required in this area, particularly with regard to finding out why certain individuals are highly emotional and whether it is possible for them to achieve a moderate response in life without the need for an emotional coping strategy. My skills as a researcher both with regard to obtaining the data and analysing it have improved and created a desire to ask more questions around maintained weight loss and potentially research further.

Personally, I would like to plan and action a pilot intervention with the aim of working with a small group of individuals with severe obesity. Qualifying as a counselling psychologist will enable me to pursue this work with a specified group to identify successful strategies to weight maintenance with the focus being primarily on the psychological wellbeing of the individual.

6.4 Conclusion

Completing this research has provided me with an opportunity to gain insight into the lives of individuals who were severely obese with the intention of obtaining a substantive theory of maintained weight loss. The participants in this study have identified that by improving their mental health their desire to improve in many other ways occurs naturally. The participants provided insight into what facilitated maintained weight loss as well as highlighting barriers in the hope that others do not

need to reach a stage of desperation. I feel to have personally gained in knowledge and insight in completing this research which I hope will enhance my future work as a counselling psychologist. I have also experienced my own challenges which have helped me grow as an individual gaining in greater self-awareness and acceptance as well as developing as a researcher.

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APPENDICEES

Appendix A

University of Wolverhampton Ethical Approval

UNIVERSITY OF WOLVERHAMPTON
KNOWLEDGE • INNOVATION • ENTERPRISE

Date 25th February 2014

[redacted],

Dear Carol

Re: Maintained Weight Loss: Facilitators and Barriers

Submitted to the Faculty of Education, Health and Wellbeing Ethics Sub-Committee Board (Health Professions, Psychology & Social Care)

The Faculty Ethics Sub-Committee (Health Professions, Psychology & Social Care) met on 17th February 2014 when your project was considered and reviewed at this meeting.

On review your research proposal was passed and given approval **(Code 2 – Pass (Researcher/Supervisor to Monitor).** You are free to begin your study contingent on addressing any minor amendments detailed below.

Supervisors must ensure the minor amendments have been completed prior to commencement of data collection.

We would like to wish you every success with the project.

Yours sincerely

H Paniagua
Dr. H. Paniagua PhD, MSc, BSc (Hons) Cert. Ed. RN RM
Chair – School Ethics Committee

D Chadwick
Dr. D. Chadwick PhD, MSc, BA (Hons). PGCE
Chair – School Ethics Committee

Appendix B
National Health Service Ethical Approval

NHS
Health Research Authority
National Research Ethics Service

NRES Committee North West - Lancaster
HRA NRES Centre - Manchester
Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Telephone: 0161 625 7818
Facsimile: 0161 625 7299

12 March 2014

Mrs Carol Cullen
Counselling Psychologist in training
C/o. Dr W Nicholls, University of Wolverhampton
Mary Seacole Building, Nursery Street, Wolverhampton
Wolverhampton
WA1 1AD

Dear Mrs Cullen

Study title:	**Maintained Weight Loss in Individuals diagnosed with Morbid Obesity: Facilitators and Barriers**
REC reference:	**14/NW/0167**
Protocol number:	**N/a**
IRAS project ID:	**141587**

Thank you for your email of 12 March, responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager Mrs Carol Ebenezer, nrescommittee.northwest-lancaster@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Appendix C
Participant Letter of Invitation

Our Ref. WN/CC/1125091

Mrs C Cullen
C/o. Dr Wendy Nicholls
University of Wolverhampton
Faculty of Health, Education, & Wellbeing
Mary Seacole Building, Nursery Street
Wolverhampton
WV1 1AD

Telephone Number: [mobile no. redacted]

Date 28th February 2014

Dear Sir/Madam,

I am writing to invite you to participate in a research project that I am conducting as part of a professional doctorate course in counselling psychology at the University of Wolverhampton. I enclose an information sheet, which explains the title and aims of the project and what taking part will involve. This research is being conducted independently from the weight loss service.

If you feel that you would like take part in this research and tell your weight loss experience in an interview, would you please contact me on the above telephone number or alternatively email me at [e-mail address redacted]. If you would prefer not to be involved, please destroy this letter. If you do decide to take part in the study or not, I would like to assure you that your care and treatment received from the weight loss programme will not be affected in any way.

Yours sincerely,

Carol Cullen
Counselling Psychologist in Training

Appendix D
Participant Information Sheet

Participant Information Sheet

Maintained weight loss: Facilitators and Barriers

My name is Carol Cullen and I am a doctoral student at the University of Wolverhampton. My supervisors are Dr Wendy Nicholls and Professor Magi Sque, their contact details are listed at the bottom of this information sheet. I am writing to you to ask whether you would consider helping me in my research by taking part in my study. Prior to doing so, it is recommended that you are fully aware of why the research is being done and what will be asked of you. The following information explains these points. Please take time to read this information and ask any questions, before deciding on whether to proceed.

What is the purpose of the study?
The aim of this study is to obtain insight into an individual's successful weight loss journey from being very overweight. Specifically looking at what helped and what hindered the individual in losing weight. It is anticipated that the information provided will contribute towards informing successful treatment plans for weight loss and its maintenance.

Why have I been chosen?
You will be either presently on a weight loss programme, or you may have maintained your weight loss for at least a year. You have the insight into what is/has worked for you as well as what has not worked.

Do I have to take part?
I must emphasize that it is entirely your decision as to whether or not you take part in this study. If you decide to take part, you are still free to withdraw at any point.

What will happen if I decide to take part?
If you decide to take part and the information sheet has been read and understood, you will be asked to sign the consent form. An interview date will then be planned at a mutually convenient time and place. At interview you will be asked questions regarding your weight loss experience. It is anticipated that the interviews will last for approximately one hour. With your permission, the interview will be recorded and this will then be typed up and all interviews will be analysed together, using grounded theory. Demographic information will be requested at the time of the interview as well as limited medical information. This is being requested in order to establish how much maintained weight has been lost and consider the types of other conditions you have had to manage at the same time as losing weight.

What are the potential benefits and risks of taking part?
In taking part you will help us to find out more about what helps and hinders an individual in their weight loss and this may improve future weight loss programmes, although there appear to be no direct benefits for you if you take part in this research. There are no risks to you in taking part outside of those you would experience in everyday life. However, by taking part, you may remember things that you may find upsetting. If this occurs, the researcher will ask you if you want to continue to participate in the interview. Any decision you make will be respected.

Will my taking part in the study be kept confidential?
Yes. All the information given about your participation in this study will be kept confidential. Your name will be changed so that you are not identifiable to anyone else except the researcher and the transcription of the interview you participate in will be stored on a password protected computer in a locked office. The researchers working on the project will have access to the information as well as the examining team. You will not be identifiable in any publication or report as the data will be grouped together and all identifying information will be removed.

What will happen at the end of the research study?
Copies of the published results and lay summaries will be made available following submission and approval of the thesis in October 2016. If you require a copy indicate this on the Consent Form and provide contact details. All data will be held in accordance with the University of Wolverhampton's recommended period of 5 years, at which time all data will be destroyed.

What if I have a problem or concern?
If you have a concern about any aspect of this study, you should ask to speak with the researchers who will do their best to answer your questions; researcher [e-mail address redacted] supervisors [e-mail address redacted] or[e-mail address redacted]**.**

Who has reviewed the study?
The study has been reviewed by the Ethic's Committee of Wolverhampton University and the National Health Service Ethical Committee.

Kind regards

Carol Cullen
Counselling Psychologist in Training

Appendix E
Consent Form

UNIVERSITY OF WOLVERHAMPTON
KNOWLEDGE ▪ INNOVATION ▪ ENTERPRISE

CONSENT FORM

Title of Project: Maintained weight loss: Facilitators and Barriers

Name of Researcher: Carol Cullen

Please initial boxes

1. I confirm that I have read and understand the information sheet dated 25th February 2014 for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and with no repercussions. ☐
3. I understand that my data will be stored securely and confidentially and that I will not be identifiable in any report or publication and that the data will be destroyed after five years. ☐
4. I understand that the researcher may wish to publish this study and any results found, for which I give my permission. ☐
5. I agree for my interview to be recorded and for the data to be used for the purpose of this study. ☐
6. I understand that data from the study may be looked at by supervisors from the university where it is relevant to my taking part in this study. I agree to these individuals having access to this data. ☐
7. I request a summary of this study which should be forwarded to the address below. ☐
   ……..
   ……..
8. I agree to take part in the above study. ☐

……..	……..	……
Name	Date	Signature

……..	……..	……
Researcher	Date	Signature

Appendix F
Participant Information Data

Participant Information Data

Name:…….

Telephone number: …….

Age: …….

Sex: Male/Female (please circle)

Start date of Weight Loss Course (WLC):…….

Weight at beginning of WLC:

_____ st _____lbs or _____KGs.

Height:
_____ft _____ins or _____m

BMI: ……..

Weight today:

_____ st _____lbs or _____KGs.

BMI (if known): …….

Any other medical diagnosis at the time of starting the Weight Loss Course:

…….

…….

…….

…….

Appendix G Participant Information Data Collated

Participant Pseudonym	Age	Sex	Height	Date started losing weight	Weight at start of weight loss	Initial BMI	Weight at interview and total weight lost	Current BMI	Comorbidities
Jane	61	F	5ft	May 2011	22st8lb (144kgs)	74.8	151kgs (3st11lb/24kgs)	64.5 (Obese Class III)	Cellulitis High Blood Pressure Arthritis in knees
David	41	M	6ft Approx.	July 2011	21st6lbs (136kgs)	40.7	19st 3lbs (2st 3lbs) (14kgs)	36.47 (Obese Class II)	None
Sarah	43	F	5ft 6ins	2010	15st 10lbs (100kgs)	35.5	12st 8lbs (3st2lb) (20kgs)	28.42 (Overweight)	Diabetes
Ian	51	M	5ft 7ins	1/8/2012	20st 6lbs (130kgs)	44.8	14st (6st6lbs) (38kgs)	30.69 (Obese, Class I)	None
Claire	57	F	5ft 9ins	Lost weight in 1997 maintained For 18 years	15st 4 lbs (97kgs)	31.59	11st 4lbs (4 st) (25kgs)	23.32 (Normal weight)	Depression
Linda	34	F	5ft 11ins	April 2011	22st 7 lbs (143kgs)	43.9	12st 7 lbs (10st) (64kgs)	24.4 (Normal weight)	Depression & Anxiety Underactive Thyroid
Charles	53	M	5ft 7ins	28.5.2011	18 st (114kgs)	39.5	12 st 7 lbs (5st7lbs) (35kgs)	27.4 (Overweight)	None

Appendix H
Debrief Sheet

UNIVERSITY OF WOLVERHAMPTON
KNOWLEDGE ▪ INNOVATION ▪ ENTERPRISE

DEBRIEF STATEMENT

Title of Project: Maintained weight loss: Facilitators and Barriers

Name of Researcher: Carol Cullen

Thank you so much for participating in this study. Your participation was very valuable to the study.

For information purposes, there was no known deception within this study. It was, as stated in the information sheet, a study to explore the experiences of individuals who were very overweight by looking into each individual's weight loss experience; what facilitated the weight loss and what barriers individuals overcame to maintain that weight loss. The aim was to research these areas, to contribute towards implementing treatment plans for weight loss and its maintenance.

It was anticipated that there would be no known risk to participants when completing the interviews other than those experienced in everyday life. Details of relevant organisations are listed below, should you feel worried or upset after taking part in this study.

Mind
15-19 Broadway, Stratford, London E15 4BQ
T: 020 8519 2122
e: contact@mind.org.uk

Samaritans
Central Charity telephone: +44 (0)20 8394 8300
Central Charity email: admin@samaritans.org.
Central Charity fax: +44 (0)20 8394 8301
Central Charity address: The Upper Mill, Kingston Road, Ewell, Surrey, KT17 2AF

BEAT
103 Prince of Wales Road, Norwich Telephone No: 0845 634 1414
www.b-eat.co.uk

If you have any further questions or concerns regarding this study, please do not hesitate to contact either myself [e-mail address redacted] or my supervisor [e-mail address redacted].

I would like to thank you for participating in this study.

Kind regards

Carol Cullen
Counselling Psychologist in Training

Appendix I

Interview Questions

The interview would begin with a broad, open question to obtain the participant's perspective on their weight loss and to allow them to say their experience.

- Tell me the story of your weight loss journey

Facilitators to maintained weight loss

- What helped you lose weight over this time? What would you say was the main contributor and why?
- Who, if anyone, influenced your weight loss? In what way did they do so?
- As you look back over your weight loss journey, is there anything you would do differently, if so, why?
- How do you feel you have managed to maintain your weight loss for at least a year?
- Could you describe the most important lessons you learned through experiencing this weight loss?
- What advice would you give to those who are now on the weight loss programme?
- Is there anything you feel I should know to better understand successful weight loss?

Barriers to maintained weight loss

- Did anything stop or hinder you losing weight over this time? If so, in what way and how did you overcome it?

- Did you put weight on? If so, did anything influence this and how did you overcome it?

Historic perspective to gain insight

- Had you tried to lose weight in the past? What was different this time?

Reflection and personal perspective as well as knowing

- Looking back over this journey, what are your thoughts and feelings of the experience now?

Identifying the participant's ability to self-awareness

- How would you describe the person you are now? How would you have described yourself then?
- What do you most value about yourself?
- How do you see yourself in two years' time?

Providing an opportunity for all questions to be answered

Is there anything you would like to ask me?

The interview questions did not alter significantly because they were felt to be providing the depth of insight and personal perspectives to the individual's constructions of maintained weight loss. There were a few areas of interest that I found needed clarity and deeper understanding. These were focused primarily with the last three participants and related to their feelings of being different to 'normal' people in society. Clarity to this perception was sought and it was reflected upon in analysis.

Appendix J

Evidence of Data Saturation

Evidence of Data Saturation for the last three participants

All the three last participants who had maintained at their goal weight following analysis were identified as having the following;

- They all experienced the negative cycle of commercial slimming clubs
- They all felt at a level of desperation when they entered into the programme.
- They all have adhered to the programme committedly.
- They all abstain from certain food types.
- They all received a sense of hope, identification, and inclusion, feeling valued, able to help others and be supported.
- They all received acceptance and self-awareness. Openness to no longer being secretive.
- They all received a sense of calm from the programme that they used to obtain from food.
- They all feel it is necessary to continue with the programme to keep maintained weight loss.
- They have all experienced a positive change with regard to their personalities and consequently their lives.

Appendix K

Lone Worker Policy

UNIVERSITY OF WOLVERHAMPTON
KNOWLEDGE • INNOVATION • ENTERPRISE

Centre for Health and Social Care Improvement

Conducting data collection off campus and working alone template

Name:
Researchers mobile contact number:
Date of Research interview:
Time of leaving home/work base:
Method of transport to interview location:
Car registration (if travelling by car):
Location of research interview (enter full postal address):
Expected start time of research interview:
Expected duration of research interview:
Agreed code, conveying the need for support:
Time of arrival at research interview destination: (to be completed by nominated colleague)
Agreed time to contact a designated colleague: (enter the time the interview is expected to end)
Time of leaving research interview destination: (to be completed by nominated colleague)

2

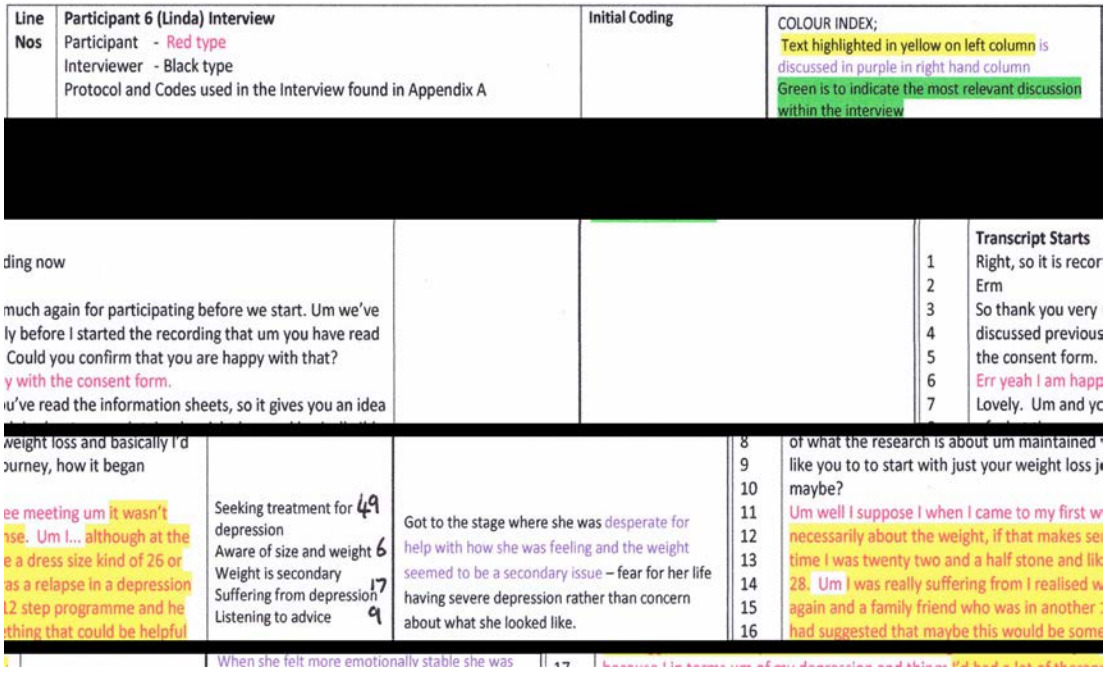
Appendix L

Examples taken from Confidential Appendix - Data Analysis

Process of Analysis for the Interview Transcripts

Following transcription and checking of each interview at least three times the analysis commenced with line by line coding. Each line of the interview was coded using gerund initial coding (show in the Interview Example 1a below). Initial coding using gerunds draws out the processes occurring within each line of the data as well as the action within the text. Charmaz (2006) stated that line by line coding is useful as a heuristic device for learning about data and the world you are looking at. My initial thoughts have been placed in the right hand column alongside the initial coding to provide the reader with my thought processes whilst in the initial stages of coding. Portions of the interview text have been highlighted in green because they were felt to signify significant changes in the interview for example; Jane (Interview with Jane, page 12) began to get upset when discussing how difficult her weight loss was for her. This was felt it may be of significance with regard to maintained weight loss. Portions of the interview text were highlighted in yellow to highlight relevant processes and actions and these were noted in purple on the right hand column. This allowed open observation of my thought processes as I analysed each interviews.

Example 1a Interview Transcript from Confidential Appendix



Line Nos	Participant 6 (Linda) Interview Participant - Red type Interviewer - Black type Protocol and Codes used in the Interview found in Appendix A	Initial Coding	COLOUR INDEX; Text highlighted in yellow on left column is discussed in purple in right hand column Green is to indicate the most relevant discussion within the interview
	[redacted]		
	ding now much again for participating before we start. Um we've ly before I started the recording that um you have read Could you confirm that you are happy with that? y with the consent form. u've read the information sheets, so it gives you an idea		Transcript Starts 1 Right, so it is recor 2 Erm 3 So thank you very 4 discussed previous 5 the consent form. 6 Err yeah I am happ 7 Lovely. Um and yc
	veight loss and basically I'd ourney, how it began ee meeting um it wasn't nse. Um I... although at the e a dress size kind of 26 or as a relapse in a depression 12 step programme and he thing that could be helpful	Seeking treatment for 49 depression Aware of size and weight 6 Weight is secondary Suffering from depression 17 Listening to advice 9	Got to the stage where she was desperate for help with how she was feeling and the weight seemed to be a secondary issue – fear for her life having severe depression rather than concern about what she looked like.
	When she felt more emotionally stable she was		

8	of what the research is about um maintained
9	like you to to start with just your weight loss j
10	maybe?
11	Um well I suppose I when I came to my first w
12	necessarily about the weight, if that makes se
13	time I was twenty two and a half stone and lik
14	28. Um I was really suffering from I realised w
15	again and a family friend who was in another
16	had suggested that maybe this would be some

Following completion of line by line coding for each interview, each line of initial coding was then given a number (identified on the interview transcripts, example 1a above). Each number represented a process identified in the initial coding in each interview transcript. All the initial codes and the frequency of these codes were indicated (see example 1b, initial coding into focused coding). The initial codes which appeared throughout the data were then elevated to focused coding which represented groupings of initial codes. The focused codes are indicated next to each initial code (see example 1b). Focused codes were compared against the decisions I made on areas in the data that I felt were relevant to the study. These decisions and the focused codes were all supported by memoing of my thoughts and ideas.

Example 1b - Initial Coding into Focused Coding

Index:-
Most frequently occurred throughout interviews
Researcher felt these were important

Code Number	Initial Coding – Reduced	Total Score for Initial Coding	Focused Coding
1a	lacking knowledge	1	ControlPowerless
1	knowledge	161	Control
2	supporting others	61	Facilitator
3a	being supported	106	Facilitator
3	lacking support	4	Barrier
4	isolated/alone	43	Suffering
5	control/lack of control	91	ControlPowerless
6	awareness/acceptance	595	Awareness
7	flexibility/fluctuating	26	Flexibility
8	not engaging	30	Seriousness
9	tools	206	Facilitator/Barr.
10	reflecting	62	Awareness

The initial codes that occurred most frequently were noted (highlighted in yellow). I also made a note of the codes I felt were pertinent to the interviews, these were also identified (highlighted in purple).

The most frequent focused codes were then compared and contrasted with the initial categories identified from relevant extracts from the data. My interpretations of the actions, incidences and processes taken from the interview transcripts were analysed from which categories were constructed

(see Appendices M and N).

Memoing was recorded constantly throughout this analysis (Appendix M).

Constant comparison was identified throughout this analysis by comparing;

- the focused codes from the interviews Example 1b.
- initial categories in Appendix N
- the memoing in Appendix M

Analytic questioning was carried out asking; what larger story do these codes tell me/what implicit meaning is the data saying/what do I think it is saying/what does it mean? The constant comparison of all of the above means of analysis provided me with an interpretation of the processes occurring to facilitate a storyline of maintained weight loss.

The process that occurred for the individual as they experienced maintained weight loss was one of growing self- awareness identified through the eight categories of ‘Normalizing’, ‘Controlling’, ‘Isolating’, ‘Seeking’, ‘Gaining’, ‘Analysing’ and ‘Choosing’ resulting in the core category of ‘Emergent Self’.

Appendix M

Samples taken from Confidential Appendices - Memoing

Index: WLP – Weight Loss Programme, CBT – Cognitive Behaviour Therapy, MI – Motivational Interviewing, numbers in bracket are line numbers from the interview transcripts identifying position of comments.

Memoing

Extracts were taken from the interviews that were felt to be pertinent to maintained weight loss. These have been analysed, compared and contrasted with each interview and the categories.

Jane (participant 1)

Childhood

Jane grew up in her family being given large portions and second servings. She said that her mother and sister were both obese.

Intellectualising

Jane appeared to need to intellectualise things and she kept her emotions under control. Jane referred to CBT and MI here;

"I like to know what the big picture is I don't like going into something that I don't know where it is going, it was quite uncomfortable to start with (Line 452), almost like manipulation" (Jane, Line 427)

'I like to know what the big picture is' provided reference to having advance notification of CBT/MI before committing to it. By knowing what it was in advance Jane could decide not to take part if it is too uncomfortable. She compared

psychological therapy as 'uncomfortable' and 'almost like manipulation', both of which seemed to indicate different levels of discomfort. They showed how vulnerable she was feeling. The meaning of manipulation is to control or influence cleverly or unscrupulously. By always ensuring that she knew what she was entering into therapeutically there were no surprises and she was in control if/when revealing anything about herself.

Emotions

Jane said that she had felt extremely sensitive all her life; it was questioned whether this was a significant factor in managing her response to food. It was questioned whether Jane would have considered the interview as 'manipulation' by the interviewer in a similar way that she experienced motivational interviewing and cognitive behaviour therapy.

"*I also weep easily so take no notice of the tears* [laughs] *Just just emotion, I'm not used to talking about myself."*

"That's something that doesn't come easy to you?" "*No. I've done this all my life so don't worry about it".* [participant laughs] "Been emotional?" "Yes."(Jane, Line 833)

As soon as her emotions appeared she dismissed them. She appeared to struggle with managing her emotions and if they arise she wants them to go as quickly as they came. Throughout the interview Jane would laugh regularly, almost making light of the meanings. She would even laugh when there was a troubling emotional aspect, as shown above.

Appendix N

Samples taken from Confidential Appendix– Constructing Categories

APPENDIX J

Participant comparisons – identifying categories
Index; L = Line of text in transcript, WLP = Weight Loss Programme, MI = Motivational Interviewing, CBT = Cognitive Behaviour Therapy

	Claire (Participant 5)	Linda (Participant 6)	Charles (Participant 7)	
Reasons for commencing weight loss Triggers – Medical/health conditions Triggers for Change	Not happy with the way she ate, not necessarily her weight (L27/28, L44-45) it wasn't about the weight loss (L536) Trigger for binge eating could have been moving out of the family home in her twenties (L138)	Relapse in depression (L14) Not necessarily about the weight (L12) Felt quite hopeless/quite suicidal (L877)	General physical difficulties around weight (L28-29) Noticed difficulty climbing stairs – out of breath(L28) Was told BMI was slightly high by GP(L32)	
Facilitators for current weight loss and maintenance Flexibility of Approach No longer a valid category- Those who maintained are not flexible in their approach	Use of tools (L268-284) Very different to other WLP, OA uses; Telephone – contacting each other Writing literature Service to others – putting in what you get out Action Plan – around food Journaling Prioritising a practical plan in helping yourself to help others Sooner or later people coming into OA have to do a plan of how they are going to approach their food (L320-322)	OA approach is quite rigid in its structure but there is choice within that structure	OA approach is quite rigid in its structure but there is choice within that structure	
Adjusting within the boundaries No longer valid	Work on their personal use of food, abstain from their food of choice and decide themselves at some time in the OA programme. Abstain a day at a time (L328-334)	NONE	NONE	
Maintaining Vigilance & Control No it is a life-long process with acceptance not control	Needs to work the 12 Steps as she says she isn't cured (L469) The literature tells us we are not cured, it's a daily reprieve (474)		Strictly three meals a day even through Christmas /birthdays etc.(L49, 62) Never alter this, never intend to (L63-64) Learned though experience of braking abstinence the consequences and won't risk it again (L64-67) He wakes up and hands his life over to his Higher Power (134)	
Gaining Self-Awareness Keep as a category – a lot of evidence of gaining insight and awareness of condition and self.	Journaling every morning on how you are feeling and sharing this with a sponsor (L283-284) Time to focus on herself (L295, 298-314) Gaining openness (L420) Radically change her (L422-423) Relaxed about life now (L425) Don't' have the urge to overeat now (L427-429) Working the steps for me has created a change in me it has changed my personality (L542-543) 'I'm very very different and so that's what I needed in order to not have to overeat I believe (L548-549) It wasn't just about the weight ever it was about me, inside me' (L555-556) She feels she is more 'real' now true to who she is (L570)	Now I can see massive parallels between my mental health and overeating (174-175) I realised that it wasn't just me that felt like this (L285-288) My problem was sugar, that was my biggest thing (L317) I always loved food/alcohol – I sought something to make me feel different about myself, a sense of not sitting with yourself (L536-540) Clearing up the wreckage and making amends is part of the 12 Step Programme which provides deeper insight and awareness (L543-548) Now I feel quite at peace with myself (L818) Feels as if it happened to someone else – feels like another person now (L893)	Things that baffled me don't baffle me anymore I am learning to mind my own business (L150-152) I used to be a fixer but I realise I am powerless over other people's decisions – life has become more manageable (L155-160) The food was my master (L164) I'm starting to face up to thing (L176) It was the fear of not being good enough (L190-191) Money was always a way around things (L195) I've kinda stuffed feelings down (L454) I am happy, I enjoy my life now(884) OA has completely and utterly changed my life (L907)	
Knowledge seeking Keep – need to understand self and condition	OA support allowed her to gain deeper understanding from others about herself (L151 – 162) In OA – talk is very real, very honest (L201)	I check food labels (L326) 12 Steps get you to look at things in a different way and not to react to things in a negative way (L549-550)	Heard about OA through a family member (L36) Sometimes you feel you have dealt with things and then something different will come up that you need to deal with (L448-449)	
Hope	Hearing other peoples stories is very powerful (L682-684)	Hearing people talk in the Group – 'every single person who spoke it	Supportive environment (L562, 568)	